South East
LOCAL HEALTH INTEGRATION NETWORK
RÉSEAU LOCAL D'INTÉGRATION DES SERVICES DE SANTÉ
du Sud-Est

48 Dundas Street West , Unit 2
Belleville, ON
K8P 1A3
Tel: 613-967-0196
Fax: 613-967-1341

48 rue Dundas Ouest, unité 2
Belleville, ON
K8P 1A3
Tél : 613-967-0196
Téléc : 613-967-1341

South East Local Health Integration Network Integrated Health Services Plan

October, 2006

Ontario

Table of Contents

Section **Page**

ACKNOWLEDGEMENTS ..... **I**

EXECUTIVE SUMMARY ..... **III**

BACKGROUND AND OBJECTIVES ..... **III**

VISION FOR HEALTH AND HEALTH CARE SERVICES ..... **III**

KEY FINDINGS FROM THE ENVIRONMENTAL SCAN ..... **IV**

- Population Health V
- Utilization of Health Services VI

PRIORITIES FOR CHANGE ..... **VII**

- Access to Care VII
  - *Access to Primary Health Care* ..... *vii*
  - *Access to Specialty Care* ..... *viii*
  - *Access to Mental Health Services* ..... *viii*
  - *Access to Addiction Services* ..... *ix*
  - *Access to Rehabilitation Services* ..... *ix*
  - *Transportation To and From Care* ..... *x*
- Availability of Long Term Care Services X
- Integration of Services Along the Continuum of Care XI
- Engagement with Aboriginal Communities XI
- Ensuring French Language Services XI
- Integration of E-Health XII
- Regional Health Human Resources Plan XII

LHIN PRIORITIES AND MOHLTC STRATEGIC DIRECTIONS ..... **XII**

ACTION PLAN ..... **XIII**

- Access to Care XIII
  - *Access to Primary Health Care* ..... *xiii*
  - *Access to Specialists* ..... *xiv*
  - *Reduce Wait Times for Treatments* ..... *xiv*
  - *Access to Mental Health Services and Addictions Services* ..... *xv*
  - *Access to Rehabilitation Care* ..... *xv*
  - *Transportation To and From Care* ..... *xv*
- Availability of Long Term Care Services XVI
- Integration of Services Along the Continuum of Care XVI
- Integration of E-Health XVI
- Regional Health Human Resources Plan XVII
- Engagement with Aboriginal Communities XVII
- Ensuring French Language Services XVII

1.0 PROVINCIAL CONTEXT 1

1.1 Background and Objectives 1
1.2 Provincial Vision and Strategic Directions 2

2.0 VISION FOR HEALTH AND HEALTH CARE IN THE SOUTH EAST LHIN AREA 4

3.0 ENVIRONMENTAL SCAN 5

3.1 The South East Local Health Integration Network Planning Area 5
3.2 Population Characteristics 7
3.2.1 Age of Population 7
3.2.2 Social and Demographic Characteristics 8
3.3 Population Health 9
3.3.1 Health Status 9
3.3.2 Health Practices 11
3.3.3 Cancer 12
3.3.4 Chronic Conditions 13
3.3.5 First Nations Population 14
3.3.6 Francophone Population 16
3.4 Utilization of Health Services 18
3.4.1 Primary Health Care Utilization 18
3.4.2 Hospital Emergency Department Utilization 24
3.4.3 Acute Care Hospital Utilization 27
3.4.4 Cancer Care 36
3.4.5 Alternate Level of Care (ALC) Days 36
3.4.6 Utilization of Inpatient Rehabilitation 38
3.4.7 Utilization of Complex Continuing Care (CCC) 39
3.4.8 Utilization of Long-Term Care Homes 41
3.4.9 Home Care 44
3.4.10 Community Services 45
3.5 Health Human Resources 48
3.6 Health Care Education and Research 51
3.6.1 Support for Academic Health Science Centres 51
3.6.2 Queen's University 51
3.6.3 Other Health Education Institutions 52
3.6.4 Clinical Research 53
3.7 E-Health Readiness 53

4.0 LHIN PRIORITIES FOR CHANGE 56

4.1 Access to Care 57
4.1.1 Access to Primary Health Care 57
4.1.2 Access to Specialty Care 59
4.1.3 Access to Mental Health Services 60
4.1.4 Access to Addiction Services 61
4.1.5 Access to Rehabilitation Services 61
4.1.6 Transportation To and From Care 62
4.2 Availability of Long Term Care Services 62
4.3 Integration of Services Along the Continuum of Care 63
4.4 Engagement with Aboriginal Communities 64
4.5 Ensuring French Language Services 64
4.6 Integration of E-Health 64
4.7 Regional Health Human Resources Plan 65

5.0 LHIN PRIORITIES AND MOHLTC STRATEGIC DIRECTIONS 66

6.0 CURRENT ACTIVITIES 68

6.1 Southeastern Ontario Integration Project (SOIP) 68
6.2 Wait Times Strategy 69
6.3 Surgical Efficiency Targets Program 70
6.4 Critical Care Strategy 71

7.0 ACTION PLAN 73

7.1 Access to Care 73
7.1.1 Access to Primary Health Care 73
7.1.2 Access to Specialists 74
7.1.3 Reduce Wait Times for Treatments 75
7.1.4 Access to Mental Health Services and Addictions Services 75
7.1.5 Access to Rehabilitation Care 76
7.1.6 Transportation To and From Care 76
7.2 Availability of Long Term Care Services 77
7.3 Integration of Services Along the Continuum of Care 77
7.4 Integration of E-Health 78
7.5 Regional Health Human Resources Plan 78
7.6 Engagement with Aboriginal Communities 78
7.7 Ensuring French Language Services 78

APPENDICES

A. Findings from the Community Engagement and Stakeholder Consultation Processes
B. Findings from the Quantitative Analysis of Population Health and Health Services Utilization

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K8P 1A3
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Fax: 613-967-1341

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Belleville, ON
K8P 1A3
Tél : 613-967-0196
Téléc : 613-967-1341

South East Local Health Integration Network
Integrated Health Services Plan

EXECUTIVE SUMMARY

October, 2006

Ontario

Acknowledgements

The South East Local Health Integration Network (LHIN) is very appreciative of the assistance provided by many individuals, organizations, and companies in the development and production of the inaugural Integrated Health Services Plan (IHSP). Their knowledge, expertise, guidance and feedback have been invaluable. The result is a comprehensive, evidence-based, community validated plan that will guide the efforts of the LHIN and Health Service Providers in the development of a true health system in South Eastern Ontario that meets the needs of our population and will continue to improve upon the excellent service that is provided today. It is not possible to name all of the contributors here, however we wish to particularly note the contributions of the following:

- Hay Group, for ensuring the timely development of a robust, comprehensive Integrated Health Services Plan that is grounded by intensive analysis of both quantitative and qualitative data and information. We wish to particularly thank Mark Hundert, Chris Helyar, and Irene Petersen-Gray
- Members of the Project Work Team (PWT) for their content expertise, and their devotion of one day per week for a total of 7 weeks to the development of the IHSP. The members of the PWT are:
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  - Allan Katz - Hospitals
  - Peter McKenna – Community Health Centres
  - Peter Munt – Academic (Health care research and education)
  - Linda Pierce – Long Term Care facilities
  - Jeannine Proulx - French language community
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Finally, we wish to thank the residents of the South East LHIN, physicians, nurses, other health professionals, support workers, labour unions and many, many others for their feedback and participation. We look forward to continuing to work together to find and implement solutions for the areas identified as initial priorities for the South East over the next three years.

Executive Summary

Background and Objectives

The Government of Ontario has established the South East Local Health Integration Network and has given it the mandate for local health system transformation.

The Government of Ontario has made better health care a key priority. It has established the South East Local Health Integration Network (SE LHIN) and has given it the mandate for local health system transformation through community engagement and enhanced local capacity to plan, coordinate, integrate and fund the delivery of most publicly funded health services.

The South East LHIN encompasses the areas of Hastings, Prince Edward, Lennox & Addington, Frontenac, Leeds and Grenville Counties (excluding the municipality of North Grenville), the cities of Kingston, Belleville and Brockville, the separated towns of Smiths Falls and Prescott, and parts of Lanark and Northumberland Counties. The South East LHIN is home to 480,127 people, or 3.8% of the population of Ontario (2004)[1]. The population resides in 45 municipalities in South Eastern Ontario.

IHSP developed through engagement and consultation with local communities, health services providers and health service agencies.

A key activity of the SE LHIN will be the development and continued refinement of an Integrated Health Services Plan. This is the first version of the plan for the South East LHIN. It has a 3 year horizon and provides an initial perspective on directions for change and includes the LHIN's vision, priorities and strategies for enhancing health care delivery through better horizontal and vertical integration of services within the South East LHIN.

This Integrated Health Services Plan (IHSP) has been developed through engagement and consultation with the local communities in the LHIN, health services providers and health service agencies under the jurisdiction of the LHIN and analysis of supporting population health and health planning data. It is expected that this IHSP will be refined through further consultation with the communities and providers in the LHIN.

Vision for Health and Health Care Services

[1] Population estimates provided from Ontario Health Data Warehouse by Ontario MOHLTC LHIN Information Management Support Centre

We propose to work with our partners to create a vision for health and healthcare in the SE LHIN.

Our vision for health and health care services will guide our work in the immediate future. We propose to work with our partners to create a vision for health and healthcare in the SE LHIN that may include the following concepts:

- Accessibility
- Patient Centredness
- Integration
- High Quality
- Sustainability

The vision and initial IHSP of the SE LHIN are rooted in the vision and strategic directions of the MOHLTC for the health care system in Ontario.

The vision and this initial IHSP of the South East LHIN will be firmly rooted in the vision and strategic directions of the Ministry of Health and Long-Term Care for the health care system in Ontario. The provincial vision is:

"***A health care system that helps people stay healthy, delivers good care when they need it, and will be there for their children and grandchildren***."

The South East LHIN IHSP is supportive of the related draft[2] strategic directions of the MOHLTC. These have been articulated by the Minister to be:

1. Renewed community engagement and partnerships in and about the health care system;
2. Improve the health status of Ontarians;
3. Ontarians will have equitable access to the care and services they need no matter where they live or their socio/cultural/economic status;
4. Improve the quality of health outcomes, and
5. Establish a framework for sustainability that achieves the best results for consumers and the community.

Key Findings from the Environmental Scan

Findings from the environmental scan have informed and guided our priorities for change.

The following are key findings from the environmental scan that have informed and guided our priorities for change. The full environmental scan including the findings from the community engagement and stakeholder consultation processes and the quantitative analysis of population health

[2] These are draft strategic directions of the MOHLTC. Final strategic directions are expected in the Spring of 2007.

and health service utilization are presented as appendices to the IHSP.

Population Health

Because of low population density (there are only 24.2 residents per square kilometre) the SE LHIN is the only one of the 12 southern LHINs considered to be rural under a definition developed by the Ontario Joint Policy and Planning Committee.

The population of the SE LHIN is older than in other LHINs.

The population of the South East LHIN is older than other LHINs. A smaller percent of the South East LHIN population is in the 25 to 49 year old age range compared to the provincial average. The South East LHIN has the highest percent of the population aged 65 years and older of any LHIN in the province[3].

The population of the SE LHIN has a significant burden of illness.

The population of the South East LHIN has a significant burden of illness. The reported prevalence of chronic conditions for South East residents is significantly higher than the Ontario average for arthritis/rheumatism, high blood pressure, asthma, diabetes, heart disease, and chronic bronchitis. The reported prevalence of arthritis/rheumatism and heart disease is the highest of all of the 14 LHINs.

Life expectancy at birth for the population of the SE LHIN is in the lowest quartile for the province.

Relative to other LHINs, the population of the SE LHIN is in the upper quartile of age standardized[4] mortality rates for: Circulatory Disease, Neoplasms, Respiratory System Disease, External Causes of Mortality (e.g. Accidents), Endocrine, Nutritional and Metabolic Diseases.

Also, the life expectancy at birth for the population of the SE LHIN is in the lowest quartile for the province.

Canadian studies of First Nations health care have consistently shown that First Nations populations have reduced life expectancy and poor health status compared to the general Canadian population.

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[3] While the current percent of population aged 65 and older is high in the South East, the projected percent growth in this age group from 2006 to 2016 (31.2%) is below the provincial average (34.6%).

[4] An adjusted rate that represents what the crude rate would have been in the study population (e.g. the South East LHIN) if that population had the same age and gender distribution as the standard population. The standard population used in this report is the Ontario 2004 population. Age-gender standardized rates can be compared across LHINs.

Utilization of Health Services

SE LHIN residents repeatedly reported difficulties in accessing both primary care and specialist physicians.

The Institute for Clinical Evaluative Sciences (ICES) concluded that "when all adjustments are considered, the East's physician supply appears similar to the provincial average"[5]. However, residents repeatedly reported difficulties in accessing both primary care and specialist physicians throughout the LHIN.

The rate of hospital admission of patients with ambulatory care sensitive conditions for South East LHIN residents is fourth highest among the 12 LHINs in southern Ontario.

Residents of the SE LHIN have the highest rate of Emergency Department visits of the southern Ontario LHINs.

Residents of the South East LHIN have the highest Emergency Department (ED) visits per population of the southern Ontario LHINs. Non-Urgent and Semi Urgent care explain most of this difference in ED use. The semi-urgent ED visit rate for the residents of the SE LHIN is the highest in Ontario, 60% above the provincial average, and more than triple the rates in four of the Greater Toronto Area LHINs.

The overall age-gender standardized hospital utilization rate for residents of the South East LHIN is 5th highest in the province and highest among LHINs where the majority of acute care is provided by academic health science centres[6].

Use of Tertiary/Quaternary inpatient hospital care by residents of the SE LHIN is second highest in the province.

Although South East LHIN residents use Primary and Secondary level inpatient acute hospital care at a rate that is approximately equal to the provincial average, their use rate for inpatient Tertiary/Quaternary acute care is second highest in the province.

The residents of the LHIN rely on Kingston General Hospital, Quinte Healthcare-Belleville and Brockville General Hospital for almost 70% of their inpatient hospital care.

The use of inpatient hospital rehabilitation by residents of the South East LHIN is more than 40% below the provincial average.

The rate of alternate level of care days for South East LHIN residents is the highest of any of the LHINs outside northern Ontario.

The age/gender standardized rate of alternate level of care (ALC) days per 10,000 population for South East LHIN residents is the 3rd highest of all LHINs, and the highest of any of the LHINs outside northern Ontario. Almost 60% of patient days spent in hospital waiting for an alternate level of care are waiting for some form of residential long-term care.

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[5] ICES Investigative Report, "Supply and Utilization of General Practitioner and Family Physician Services in Ontario", August 2005.

[6] The SE LHIN is home to the South Eastern Ontario Health Sciences Centre.

The SE LHIN ratio of people waiting in the community for admission to a long term care bed to the total number of LTC beds the third highest of all of the LHINs in Ontario.

The average number of people waiting in the community for admission to a long term care facility in September 2005 was equal to 29.5% of the total number of LTC beds in the South East LHIN. This is the third highest ratio of community wait list to available beds of all of the LHINs in Ontario.

However, the number of beds in Long-Term Care Homes per population aged 75 years and older in the South East is 102.5 which is higher than the provincial average of 99.7.

Priorities for Change

For the most part, the health system in the SE LHIN is working well.

The analysis of the health status of the population, the utilization of health services, the capacity and capability of health service providers in the LHIN and importantly the community engagement and stakeholder consultation processes undertaken as part of the development of this Integrated Health Services Plan for the South East LHIN have convinced us that, for the most part, the local health system is working well. However, we have identified several key priorities for change that will allow the system to respond even more expeditiously and comprehensively to the health services needs of the population. These are discussed briefly in the following paragraphs. It is important to note that these are all priorities for the LHIN; the order of presentation is not intended to suggest any relative importance among them.

Access to Care

Residents of the SE LHIN report some difficulties in accessing needed health services.

Access to care is a major issue within the South East LHIN. Different communities, different special needs populations and different geographies have different issues, but residents throughout the LHIN report that they experience some difficulties in accessing needed health services.

Access to Primary Health Care

The relatively large number of people in the SE LHIN with chronic diseases and the relatively high rate of hospitalization for ambulatory care sensitive conditions suggest a need for improved primary health care services, especially for health education and disease management.

Access to family physicians was identified as a priority issue in all parts of the LHIN, except Prince Edward County.

However, difficulty in gaining access to primary care physician services was overwhelmingly identified by both the general public and health services providers as a priority issue in all areas of the SE LHIN, except Prince Edward County. An inadequate supply of family physicians was reported as the cause for these difficulties. Importantly, there appears to be significant variation in physician supply across the LHIN such

that some areas of the SE LHIN may have more or less access to family physician services than others.

There is a need for health education and chronic disease management services.

The apparent shortage and lack of access to primary care physicians are likely impediments to effective primary health care in the SE LHIN. In addressing this issue, consideration should be given to integrated, multi-disciplinary models of primary health care that have been shown to be effective, especially as vehicles for delivering health education and disease management services for people with chronic diseases.

Access to Specialty Care

There are significant geographic barriers to accessing specialist physicians and supporting services.

The ability to access specialist physician care was identified as a concern in all communities, whether urban or rural. Geographic barriers to accessing specialist physicians were routinely identified, no matter how near or distant the community from the urban centres where specialists practice. With very few exceptions, patients are required to travel to Kingston, Belleville, Trenton or Ottawa to access specialist care. The need to travel, particularly if multiple appointments are required, becomes a significant barrier to accessing needed specialist care.

Once patients are able to access a specialist physician, access to hospital treatment is as good as elsewhere in the province.

Supply issues, as well as issues of geographic access were identified as being barriers to access. Specialty groups most commonly indicated as in short supply included orthopaedics, psychiatry, obstetrics and gynaecology, dermatology, rheumatology, paediatrics and plastic surgery.

However, it appears from the data regarding rates of hospitalization for secondary and tertiary hospital care, that once patients are able to access a specialist physician, access to inpatient and outpatient hospital treatment is as good as elsewhere in the province.

Access to Mental Health Services

There are difficulties in accessing the entire continuum of mental health services.

There are reported difficulties in accessing the entire continuum of mental health services, from crisis care to longer term community support in all communities within the SE LHIN.

Crisis care services were identified as a particular challenge in many communities. Communities outside of the urban centres of Kingston and Belleville are relying on telephone access to psychiatrists and crisis teams in those cities to support crisis psychiatric care in the local ED. Although this support is available, they report that it is difficult to gain access to inpatient psychiatric care when it is required.

People with long term or chronic mental health problems also identified issues with accessing services, especially ambulatory care and community support services. Access issues were reported to be especially problematic with respect to psycho-geriatric services, child and adolescent psychiatry, people with concurrent disorders, homeless people with mental health problems and forensic psychiatry.

Access to Addiction Services

People have a significant problem in accessing addiction services throughout the region.

It is reported that people have a significant problem in accessing addiction services throughout the region. These patients often have to leave their home community to access treatment. Outside of the urban settings, there are no local withdrawal management or detoxification options available. It was reported that transportation is difficult to obtain or prohibitively expensive for patients who do seek services outside their local community. Also, patients have difficulty with medication management because they often lack family physicians for follow-up and treatment management. It is reported that supportive housing options to help these patients stay in the community are inadequate throughout the South East.

Access to Rehabilitation Services

There appears to be a shortage of hospital inpatient rehabilitation services in the South East LHIN compared to other communities in Ontario. Residents of the SE LHIN use inpatient rehabilitation at a rate far below the provincial average and it is reported that there is a problem in accessing inpatient rehabilitation services.

There are significant deficits in the availability of and access to community rehabilitation services.

This might not be a significant problem where there is adequate access to community rehabilitation services. However, it is reported that there are also significant deficits in the availability of and access to community rehabilitation services. Importantly, health service providers indicate that the demand for insured or publicly funded in-home rehabilitation services exceeds the supply, and patients must wait for care. Constraints on hospital budgets limit their ability to provide outpatient rehabilitation services. Hospital outpatient services are further limited by difficulties in attracting therapists, especially in the smaller, more rural hospitals.

Even when patients are able to pay for privately funded services, it is reported that the shortage of therapists makes timely access to these private services difficult; especially rehabilitation services delivered in a person's residence.

Transportation To and From Care

Emergency transportation services are well provided across the region.

Stakeholder consultation revealed a consensus that emergency transportation (ambulance) services are well provided across the region. However, participants were quick to note that while it is relatively easy to get a patient to emergency services, transporting them back from services when they are no longer emergencies can be a particular challenge.

Transportation to non-emergency medical care is a concern in all SE LHIN communities.

Similarly, transportation to non-emergency medical care was identified as a concern in all communities. Those without their own transportation must rely on other transportation options, which are reportedly lacking in most communities or inaccessibly expensive. Only the large urban centres have public transportation options. Although private medical transportation services and taxis are available in most communities, and some transportation services are available through community support services, these options are reportedly inadequate to meet current demand. Moreover, it is reported that wheelchair or stretcher accessible transportation options are not available in many communities. People in need of these services must rely on (and pay for) private medical transportation services to provide transportation.

Also, transportation of patients between hospitals for needed specialized treatments and diagnostic services requires improvement, especially urgent, time dependent patient transportation.

Availability of Long Term Care Services

People in the South East LHIN need to wait for residential long-term care services.

People in the South East LHIN need to wait for residential long-term care services (complex continuing care, nursing homes and homes-for-the-aged). Almost 60% of patient days spent waiting for an alternate level of care are waiting for residential long-term or continuing care. People in the community are also waiting for admission to long term care homes. The ratio of the people waiting for admission to the number of beds available in the SE LHIN is the third highest of all the LHINs in Ontario, and it has been increasing.

Residential care beds are only one component of the long-term care continuum. Private retirement homes, supportive housing units, and in-home services are all other ways that long-term care needs can be met. However, it is reported that these alternative modalities of long-term care services are also in short supply in all communities in the SE LHIN.

quality of health services and the health of francophone residents.

Integration of E-Health

Sharing information along the continuum of care is especially important in addressing the needs of the large number of people with chronic diseases in the SE LHIN.

The findings of the Ontario Hospital Association 2005 Electronic Health Record (EHR) Readiness Survey suggest that hospitals in the South East LHIN are relatively less prepared for sharing patient information with providers other than hospitals than are hospitals in other parts of the province. This finding was also described in our stakeholder consultation sessions. Other agencies are apparently no better prepared for electronic sharing of patient information. Most health services providers indicated the need for an electronic patient record to make current patient information available to all providers. Without such a tool, there will be duplication, inefficiencies and potential errors. It was suggested that sharing information is especially important in addressing the needs of the large number of people with chronic diseases as they receive services along the continuum of care.

Regional Health Human Resources Plan

The LHIN should take a leadership role in developing an overall health human resources plan for the region.

There is recognition within the health care system that the availability of sufficient and qualified health care workers across numerous disciplines and occupation groups is one of the leading issues. Until recently, no appropriate systems or structures existed to support human resource planning and development at the national, provincial or local level. Most participants in the stakeholder consultation sessions felt that the LHIN should take a leadership role in developing an overall health human resources plan for the region.

LHIN Priorities and MOHLTC Strategic Directions

The following exhibit shows the relationship of the priorities for change of the South East LHIN with the draft strategic directions set out by the Ministry of Health and Long-Term Care (MOHLTC). As can be seen each SE LHIN priority for action addresses one or more of the MOHLTC strategic directions, and all of the MOHLTC strategic directions are addressed by the SE LHIN priorities for change.

MOHLTC Draft Strategic Directions	SE LHIN Priorities for Change						
	1 Access To Care	2 Availability Of Long Term Care Services	3 Integration Of Services Along Continuum	4 Engagement With Aboriginal Communities	5 Ensuring French Language Services	6 Integration Of E-Health	7 Regional Health Human Resources Plan
Renewed community engagement and partnerships in and about the health care system:	X		X	X			X
Improve the health status of Ontarians:	X		X	X	X		X
Ontarians will have equitable access to the care and services they need no matter where they live or their socio/cultural/economic status	X	X	X	X	X		X
Improve the quality of health outcomes	X		X			X	
Establish a framework for sustainability of the health care system that achieves the best results for consumers and the community	X	X	X			X	X

Action Plan

Working with our partners, we will establish specific targets and timelines for improvement.

Over the next 3 years, the South East LHIN commits to the following initiatives that will focus on developing plans and implementing system changes to address each of its priorities and resolve issues related to these priorities. Working with our partners, we will establish specific targets and timelines for improvement appropriate to each change initiative. We will report on our progress in achieving our objectives for each initiative.

Access to Care

The South East LHIN will further investigate, develop plans and work with others to implement system changes that will improve access to care across the LHIN. We will work to reduce the often significant barriers to care experienced by special needs populations in the South East.

Access to Primary Health Care

We will focus on further developing integrated, multi-disciplinary models of primary health care.

The SE LHIN will develop and implement regional and sub-regional strategies to:

- increase the supply of primary health care providers, and
- increase the service capacity of primary health care providers.

These strategies will focus on further developing integrated, multi-disciplinary models of primary health care in the SE LHIN that have been shown to be effective vehicles for delivering primary health care services, especially for people with chronic diseases. Focusing on the use of multi-

disciplinary teams should expand the capacity of primary health care within the region by allowing other professionals, in addition to physicians, to be involved, within their scope of practice, in responding to the needs of patients.

Access to Specialists

The LHIN will work with providers to enhance the recruitment of necessary additional medical specialists and subspecialists.

The SE LHIN will develop and implement regional strategies to:

- selectively increase the local supply of medical specialists, and
- improve access to medical specialists (and supporting diagnostic services) for consultation.

It has been suggested that increasing the supply and capacity of primary health care providers will reduce the use of specialists in providing primary health care type assessments and follow up care. By reducing the referral rate from primary health care providers, the wait times to access a specialist for assessments and treatment planning should be reduced.

Selectively, and based on its Health Human Resources Plan, the LHIN will work with providers to recruit necessary additional medical specialists and subspecialists. This, too, should reduce the wait time to access specialists for assessment and treatment planning

Reduce Wait Times for Treatments

Our focus will be improving the queuing mechanisms for accessing services to ensure patients with highest need have priority.

Wait time for treatment is a function of availability of human resources, technologies and facilities and the queuing models used for accessing these resources. Over the next three years the LHIN will investigate the types of service that have lengthy wait times for necessary care. For these services, in concert with the provincial wait times strategy, the LHIN will work with providers to develop plans to reduce wait times for services. The focus of these initiatives will be improving the queuing mechanisms for accessing services, improving management of the queues for services to ensure patients with highest need have priority access, improving the efficiency of service delivery and as necessary, increasing the capacity to provide services.

Access to Mental Health Services and Addictions Services

Particular attention will be paid to developing and implementing models to ensure access to appropriate and timely mental health care and addiction services for residents of the more remote parts of the SE LHIN.

The LHIN will further investigate, develop plans and work with providers to reduce barriers to accessing existing mental health services and addiction services and to increase the supply of these services across the region. The LHIN will devote efforts toward expanding the capacity to provide mental health services and addictions services. Particular attention will be paid to developing and implementing models to ensure access to appropriate and timely mental health care and addiction services for residents of the more remote parts of the SE LHIN.

An important component of this initiative (and in conjunction with the initiative to increase the capacity to provide primary health care) will be the investigation of a 'shared-care' model for mental health services that relies heavily on primary health care providers to be integral components of the system for maintaining and restoring mental health.

Access to Rehabilitation Care

The SE LHIN will investigate the dimensions of the apparent deficit in rehabilitation services and develop strategies to increase capacity.

The apparent shortage of hospital inpatient rehabilitation services is a disadvantage for residents of the South East LHIN and is creating system flow issues as patients wait in acute care hospitals for access to rehabilitation services. The SE LHIN will investigate the dimensions of this apparent service deficit and the types of services in need of increased capacity. Similarly, the community is concerned about access to and the affordability of outpatient and in-home rehabilitation services. The SE LHIN will investigate the dimensions of this issue and develop plans, within the funding framework of the Ministry of Health and Long-Term Care, to address the concerns and needs of the population of the SE LHIN for these services.

Transportation To and From Care

The SE LHIN will develop plans to improve access to transportation for care.

The SE LHIN will investigate the issues surrounding:

- transportation to and from elective outpatient and inpatient care and
- inter-hospital transportation of patients for specialized treatment and diagnostic services.

The LHIN will work with its partners to develop plans to improve access to transportation for care. The SE LHIN will also investigate and develop strategies to address the problem of securing and paying for appropriate transportation home

after an episode of emergency care when personal means of transportation are unavailable or inappropriate.

Availability of Long Term Care Services

The SE LHIN will develop a plan to realign current capacity to better meet the needs of the population and/or to increase the capacity of one or more long-term care modalities.

The SE LHIN will work with health service providers to investigate the appropriateness of the use and the adequacy of the availability of different modalities of long-term care, including:

- Home Support
- Home Care
- Supportive Housing
- Long Term Care Homes
- Complex Continuing Care

As necessary, the SE LHIN will develop a plan to realign current capacity to better meet the needs of the population and/or to increase the capacity of one or more long-term care modalities.

Integration of Services Along the Continuum of Care

The LHIN will work with providers to identify and adopt best practice models for eliminating barriers and improving the flow of patients along the continuum of care.

The LHIN will work with providers to identify and adopt best practice models in Ontario and beyond for eliminating barriers and improving the flow of patients along the continuum of care. The focus of these initiatives will be facilitating the movement of patients between providers in different geographies within a sector (e.g. acute care hospitals) and between providers in different sectors within or across geographies. Integration of services will be especially important for patients with chronic diseases who have ongoing rather than episodic interaction with multiple rather than individual elements of the health system.

Integration of E-Health

The SE LHIN will work with providers to implement an integrated strategy for acquiring and deploying e-health technologies within the LHIN.

The SE LHIN will work with providers in the SE LHIN to first develop and then implement an integrated strategy for acquiring and deploying e-health technologies within the LHIN. The SE LHIN will then assist and monitor the performance of health service providers in the implementation of the e-health strategy. The objective of this initiative will be to improve the sharing and exchange of patient information among providers along the continuum of care in support of the care for individual patients.

Regional Health Human Resources Plan

SE LHIN will develop a model for the most effective and efficient deployment of health human resources in the different sub-areas of the LHIN.

The SE LHIN will initiate activities to develop a model for the most effective and efficient deployment of health human resources in the different sub-areas of the LHIN. It will develop an inventory of existing health human resources and a strategy for recruiting additional, needed resources and for deploying the resulting complement of health human resources in relation to SE LHIN's new model for the delivery of care.

Health Human Resource Planning will also need to focus on improving the availability of French language services within the South East LHIN.

Engagement with Aboriginal Communities

We will engage with the Aboriginal communities within the SE LHIN to ascertain issues and identify opportunities to improve health services and the health of the Aboriginal population in the SE LHIN.

Ensuring French Language Services

We will work to increase the range of health services that are available in French.

We will work with the francophone community to develop a comprehensive plan to improve access to French language health services in the South East LHIN. We will encourage and support initiatives designed to attract and retain French speaking service providers and facilitate access to French language health services. The focus of these initiatives will be to reduce language barriers to accessing health services for the francophone population in the South East LHIN.

South East
LOCAL HEALTH INTEGRATION NETWORK
RÉSEAU LOCAL D'INTÉGRATION DES SERVICES DE SANTÉ
du Sud-Est

48 Dundas Street West , Unit 2
Belleville, ON
K8P 1A3
Tel: 613-967-0196
Fax: 613-967-1341

48 rue Dundas Ouest, unité 2
Belleville, ON
K8P 1A3
Tél : 613-967-0196
Téléc : 613-967-1341

South East Local Health Integration Network Integrated Health Services Plan

October, 2006

Ontario

1.0 Provincial Context

1.1 Background and Objectives

The Government of Ontario has established the South East Local Health Integration Network and has given it the mandate for local health system transformation.

The Government of Ontario has made better health care a key priority. It has established the South East Local Health Integration Network (SE LHIN) and has given it the mandate for local health system transformation through community engagement and enhanced local capacity to plan, coordinate, integrate and fund the delivery of most publicly funded health services.

A key activity of the SE LHIN has been and will be the development and continued refinement of an Integrated Health Services Plan (IHSP). This is the first version of the plan for the South East LHIN. It has a 3 year horizon and provides an initial perspective on directions for change and includes the LHIN's:

- Vision
- Priorities
- Strategies

for enhancing health care delivery through better horizontal and vertical integration of services within the South East LHIN. It is expected that the IHSP will be updated annually to reflect changes in the population, changes in the health system and improving information and insights into both.

IHSP developed through engagement and consultation with local communities, health services providers and health service agencies.

This Integrated Health Services Plan has been developed through engagement and consultation with the local communities in the LHIN, health services providers and health service agencies under the jurisdiction of the LHIN and analysis of supporting population health and health planning data. It is expected that the IHSP will be refined through further consultation with the communities and providers in the LHIN.

The essential principles for the development of this first IHSP have been[7]:

- Community Engagement: health needs are best developed, and decisions made, by the community, health care providers and the people they serve

[7] Taken from "Roadmap to the Integrated Health Service Plan, January, 2006, Ontario Ministry of Health and Long-Term Care.

- Cooperation and Coordination: communities, health service providers, local health integration networks and the government must work together to reduce duplication and better coordinate health service delivery
- Equity and Diversity: commit to equity and respect for diversity in communities, including respecting the requirements of the French Language Services Act in serving Ontario's French speaking community and recognizing the role of First Nations and Aboriginal peoples in the planning and delivery of health services in their communities; access to health services will not be limited to the geographic area of the local health integration network in which an Ontarian lives
- Accountability and Transparency: demonstrate that the health system is governed and managed in a way that reflects the public interest and that promotes efficient delivery of high quality health services to all Ontarians
- Sustainability: an integrated health system that delivers the health services that people need, now and in the future

1.2 Provincial Vision and Strategic Directions

This initial IHSP of the South East LHIN is firmly rooted in the vision of the Ministry of Health and Long-Term Care:

"A health care system that helps people stay healthy, delivers good care when they need it, and will be there for their children and grandchildren."

"***A health care system that helps people stay healthy, delivers good care when they need it, and will be there for their children and grandchildren.***"

The South East LHIN IHSP is supportive of the related draft[8] strategic directions of the MOHLTC. These have been articulated by the Minister to be:

1. Renewed community engagement and partnerships in and about the health care system:
   - Effective governance structures and processes
   - Community awareness and engagement are core elements/processes in local health system planning
   - Partnerships with other participants in the local health care system including public health and primary care groups
   - Active participation in local community planning processes

[8] These are draft strategic directions of the MOHLTC. Final strategic directions are expected in the Spring of 2007.

2. Improve the health status of Ontarians:
   - Improved health of all Ontarians, especially groups with the poorest health status
   - Enhanced uptake of provincial disease screening programs
3. Ontarians will have equitable access to the care and services they need no matter where they live or their socio/cultural/economic status:
   - Reduced wait times for key services
   - Reduced barriers to access
   - More effective health human resource planning and management
   - Appropriate supports to enable Ontarians to age in the most appropriate place
4. Improve the quality of health outcomes:
   - The consumer is at the centre of the planning and co-ordination of health services and chronic disease management
   - Leadership and participation in continuous quality improvement of the health system
   - Improved integration and coordination of health services and facilities related to prevention, promotion, diagnosis, treatment, rehabilitation, and palliative care that is based on the population's need
   - Improved safety and effectiveness of health services
5. Establish a framework for sustainability of the health care system that achieves the best results for consumers and the community:
   - Equitable allocation of health resources according to the health needs of the population including disease management
   - Optimized use of available resources to deliver health care
   - Planning and decision making is based on evidence, analysis of need and value of investment
   - Efficient service delivery
   - Increased use of appropriate care settings
   - The local health system is moving toward an electronic health information system
   - Financial stability

2.0 Vision for Health and Health Care in the South East LHIN Area

We propose to work with our partners to create a vision for health and healthcare in the SE LHIN area.

Our vision for health and health care services will guide our work on behalf of the residents of the SE LHIN area. We propose to work with our partners to create a vision for health and healthcare in the SE LHIN area that may include the following concepts:

- Accessibility
- Patient Centeredness
- Integration
- High Quality
- Sustainability

3.0 Environmental Scan

3.1 The South East Local Health Integration Network Planning Area

The South East LHIN area[9] encompasses Hastings, Prince Edward, Lennox & Addington, Frontenac, Leeds and Grenville Counties, the cities of Kingston, Belleville and Brockville, the separated towns of Smith Falls and Prescott, and parts of Lanark and Northumberland Counties. The following map shows the areas included within the South East LHIN.

Exhibit 3.1: Map of S.E. LHIN

The South East LHIN area is home to 480,127 people, or 3.8% of the population of Ontario (2004) [10]. The population reside in 45 municipalities in South Eastern Ontario.

Exhibit 3.2: 2004 Population for SE LHIN Area Municipalities [11]

Residence Area	2004 Popn	% of SE LHIN Total	Cumul. % of Total
Kingston	121,474	25.3%	25.3%
Belleville	48,273	10.1%	35.4%
Quinte West	43,413	9.0%	44.4%
Prince Edward County	26,338	5.5%	49.9%
Brockville	22,366	4.7%	54.5%
South Frontenac	17,808	3.7%	58.2%
Greater Napanee	16,045	3.3%	61.6%
Loyalist	15,384	3.2%	64.8%
Elizabethtown-Kitley	10,508	2.2%	67.0%
Rideau Lakes	10,334	2.2%	69.1%
Brighton	10,188	2.1%	71.3%
Smiths Falls	9,533	2.0%	73.2%
Leeds & Thousand Isl	9,529	2.0%	75.2%
Augusta	8,083	1.7%	76.9%
Stone Mills	7,801	1.6%	78.5%
Drummond/N Elmsley	7,271	1.5%	80.1%
Edwardsburgh/Cardinal	7,031	1.5%	81.5%
Perth	6,323	1.3%	82.8%
Tweed	5,855	1.2%	84.1%
Tay Valley	5,844	1.2%	85.3%
Gananoque	5,435	1.1%	86.4%
Stirling-Rawdon	5,135	1.1%	87.5%
Central Frontenac	4,782	1.0%	88.5%
Centre Hastings	4,529	0.9%	89.4%
Prescott	4,320	0.9%	90.3%
Hastings Highlands	4,317	0.9%	91.2%
Bancroft	4,314	0.9%	92.1%
Marmora And Lake	4,272	0.9%	93.0%
Tyendinaga	4,116	0.9%	93.9%
Montague	3,743	0.8%	94.6%
Athens	3,237	0.7%	95.3%
Merrickville-Wolford	3,101	0.6%	96.0%
Front Of Yonge	2,862	0.6%	96.6%
Addington Highlands	2,520	0.5%	97.1%
Madoc	2,163	0.5%	97.5%
North Frontenac	1,926	0.4%	97.9%
Deseronto	1,882	0.4%	98.3%
Frontenac Islands	1,718	0.4%	98.7%
Faraday	1,631	0.3%	99.0%
Tyendinaga Mohawk Ter	1,485	0.3%	99.3%
Carlow/Mayo	842	0.2%	99.5%
Wollaston	691	0.1%	99.6%
Tudor And Cashel	680	0.1%	99.8%
Westport	663	0.1%	99.9%
Limerick	362	0.1%	100.0%
SE LHIN Total	480,127	100.0%	

[10] Population estimates provided from Ministry of Health and Long-Term Care, Provincial Health Planning Database by Ontario MOHLTC LHIN Information Management Support Centre. It should be noted that there are many approaches to estimating population size; wherever possible we have used population estimates provided by MOHLTC. Estimates developed by others, such as municipalities, Census Canada, etc. may differ slightly.

[11] Population estimates by municipality provided from Ministry of Health and Long-Term Care, Provincial Health Planning Database by Ontario MOHLTC LHIN Information Management Support Centre.

The SE LHIN is the only southern LHIN considered to be rural under a JPPC definition.

The SE LHIN geographic area covers 19,473 square kilometres, making it the 4th largest of the 14 LHINs in Ontario. There are only 24.2 residents per square kilometre in the SE LHIN area. The low population density of the SE LHIN area creates transportation challenges for residents and makes it difficult for health care providers to serve a widely distributed population while at the same time meeting provincial targets for efficiency. The SE LHIN is the only one of the 12 southern LHINs that could be considered to be rural under a definition developed by the Ontario Joint Policy and Planning Committee (JPPC).

Additionally, within the boundaries of the LHIN are Queen's University, the Royal Military College, Loyalist College, St. Lawrence College, two Canadian Forces bases and 7 penitentiaries whose transient populations are not included in the official population estimate.

3.2 Population Characteristics

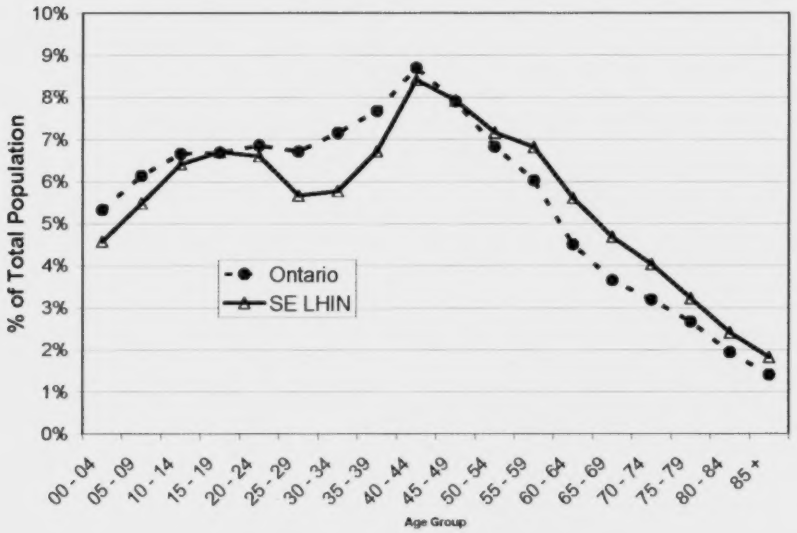
3.2.1 Age of Population

The South East LHIN has the highest percent of the population aged 65 years and older of all the LHINs in the province.

The population of the South East LHIN is older than other LHINs. A smaller percent of the South East population is in the 25 to 49 year old age range, and a higher percent is aged 60 and older compared to the provincial average. The South East LHIN has the highest percent of the population aged 65 years and older of any LHIN in the province[12].

[12] While the current percent of population aged 65 and older is high in the South East, the projected percent growth in this age group from 2006 to 2016 (31.2%) is below the provincial average (34.6%).

Exhibit 3.3: Comparison of SE LHIN and Ontario Percent Distribution of 2005 Population by Age Cohort[13]



3.2.2 *Social and Demographic Characteristics*

The exhibit following provides an overview of the social and demographic characteristics of the population of the SE LHIN area[14].

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[13] Population estimates from unpublished, draft population data from Ontario Ministry of Finance, Spring 2006.

[14] This data, as well as the health status, health practices and outcome data presented later in this report, is taken from the data sets for the "LHIN Population Health Profiles" created by the Ontario MOHLTC Health System Intelligence Project in September 2005. Each LHIN has been provided with a CD of data and indicators, and with notes that provide detailed information on each indicator including definitions, data sources, methodology, limitations, and data quality concerns. The sources of these data include Statistics Canada 2001 Census of Canada, Canadian Institute of Health Information (CIHI) Hospital Discharge Abstract Database, MOHLTC Provincial Health Planning Database and Statistics Canada Canadian Community Health Survey (2003)

Exhibit 3.4: SE LHIN Area Social and Demographic Characteristics[15] [16]

Health Indicator	Ontario Total / Average	South East	Comment
Social & demographic characteristics (2001, unless indicated otherwise)			
Annual Population Growth Rate 1994-2004 (%)	1.5%	1.4%	
Dependency Ratio (2004)	45.4	45.7	
Senior Population: % aged 65+ (2004)	12.8%	15.8%	Highest in Ontario
% of all Census families, with children, headed by Lone parent	23.4%	24.0%	
% of Lone parent families headed by Female	82.5%	81.6%	
% of Lone parent families headed by Male	17.5%	18.4%	
% population reporting English mother tongue	71.9%	92.2%	Highest in Ontario
% population reporting French mother tongue	4.7%	2.6%	
% of population who are Immigrants	26.8%	9.3%	Lowest Quartile
% of population who are *Recent* Immigrants (1996-2001)	4.8%	0.7%	Lowest Quartile
% of population who are visible minorities	19.1%	2.6%	Lowest Quartile
% population of Aboriginal identity	1.7%	2.0%	
Labour force participation rate (% population in labour force)	67.3%	62.4%	Lowest Quartile
Unemployment rate (2005)	6.6%	6.3%	
Incidence of low income (% population age 15+ below LICO)	14.4%	13.3%	
% of population (age 20+) with less than grade 9 education	8.7%	7.3%	Lowest Quartile
% population without high school graduation certificate	25.7%	27.3%	
% population with completed post-secondary education	48.7%	46.3%	

3.3 Population Health

A first step in understanding a population's need for services is to gain an understanding of the characteristics of the population and its underlying health status. Differences in health status indicators may well explain why differences in utilization exist within or across regions, or may point to an issue of unmet need within specific population groups or geographies.

3.3.1 Health Status

Population of the South East LHIN has a significant burden of illness compared to the rest of the province.

The exhibit following shows results for selected general health status and health outcome indicators for the South East LHIN area population and for the Ontario population as a whole. The "comment" column describes how the South East LHIN result compares to the distribution of results from all 14 LHINs.

[15] Ontario MOHLTC Health Intelligence Project, Population Health Indicator data, 2004

[16] The Dependency Ratio is the ratio of the combined child population (aged 0 to 14) and elderly population (aged 65 and over) to the working age population (aged 15 to 64). LICO is the low-income cut-off, the income level where people spend disproportionate amounts of money for food, shelter, and clothing.

Exhibit 3.5: General Health Status and Health Outcome Indicators for SE LHIN Area Population[17] [18]

Health Indicator	Ontario Total / Average	South East	Comment
General Health Status, 2003 (and 2005, where available)			
% Population (age 12+) with Excellent or Very Good health	57.4%	54.9%	Lowest Quartile
% Population (age 12+) with an Activity Limitation (2005)	29.4%	34.7%	Upper Quartile
Female life expectancy at birth	82.1	80.3	Lowest Quartile
Male life expectancy at birth	77.5	75.8	Lowest Quartile
Health Outcomes			
% Low birth weight babies (1999-2001)	5.6%	5.5%	
Preterm birth rate per 1000 (1999-2001)	70.9	72.0	
Infant mortality rate per 1000 livebirths (1999-2001)	5.4	5.1	Lowest Quartile
Total Crude mortality rate per 100,000 (2000-2001)	685.7	944.4	Highest in Ontario
Age-standardized mortality rate (total) per 100,000	602.6	695.1	Upper Quartile
ASMR by ICD-10 chapter, rate per 100,000 (2000-01)			
Circulatory system diseases	209.1	243.1	Upper Quartile
Neoplasms	181.4	199.9	Upper Quartile
Respiratory system diseases	45.4	57.9	Upper Quartile
External causes of mortality	32.6	40.9	Upper Quartile
Endocrine, nutritional & metabolic diseases	26.1	29.9	Upper Quartile
% of all deaths that occur before age 65	21.3%	19.8%	Lowest Quartile
% of all deaths that occur before age 75	41.2%	40.2%	Lowest Quartile
Total Potential Years of Life Lost (2000-2001 avg), rate per 100,000 population <75 yrs.	4,864	6,078	Upper Quartile
PYLLs by ICD-10 chapter (top 5 chapters), rate per 100.000 population age <75 (2000-2001)			
Neoplasms	1,590.3	1,998.0	Highest in Ontario
Circulatory system diseases	852.9	1,203.5	Upper Quartile
External causes of mortality	834.3	1,058.2	Upper Quartile
Perinatal conditions	266.5	154.4	Lowest Quartile
Symptoms, signs not elsewhere classified	234.0	248.8	

As can be seen, the population of the South East LHIN area has a significant burden of illness. For example, the population of the SE LHIN area is in the upper quartile for the province on outcome measures such as:

- Age standardized[19] mortality rate (ASMR)
- Circulatory Disease
- Neoplasms
- Respiratory System Disease
- External Causes of Mortality (e.g. injuries)

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[17] Ibid

[18] ASMR: Age Standardized Mortality Rate; ICD: International Classification of Diseases

[19] An adjusted rate that represents what the crude rate would have been in the study population (e.g. the South East LHIN) if that population had the same age and gender distribution as the standard population. The standard population used in this report is the Ontario 2004 population. Age-gender standardized rates can be compared across LHINs.

- Endocrine, Nutritional and Metabolic Diseases

Also, the life expectancy at birth for the population of the SE LHIN area is in the lowest quartile for the province.

3.3.2 Health Practices

Poor health practices are known to be related to increased risk of chronic disease, mortality and disability.

Daily smoking and heavy drinking rates are higher for South East residents relative to the province. Based on Body Mass Index, the combined prevalence of being overweight/obese is greater for the South East population (52.2%) than in Ontario (48.5%) as a whole.

However, residents of the South East are more likely to regularly use seatbelts and are less likely to report having life stress.

The initial point of access for most medical care is through a primary care physician. Medical doctors also play a key role in coordinating care and managing chronic conditions. Interestingly, despite many comments in the community engagement process regarding difficulties in accessing a family practitioner, the reported rate of engagement with physicians in the South East LHIN area is similar to the rest of the province. South East residents report only slightly below provincial average rates for having a regular medical doctor (90.9%) and slightly higher rate for consultation with a medical doctor within the past year (81.8%).

The exhibit following compares a number of selected health practices or residents of the South East LHIN area with residents of the province as a whole.

Exhibit 3.6: Rates of Health Practices and Use of Preventive Care for SE LHIN Area Residents[20]

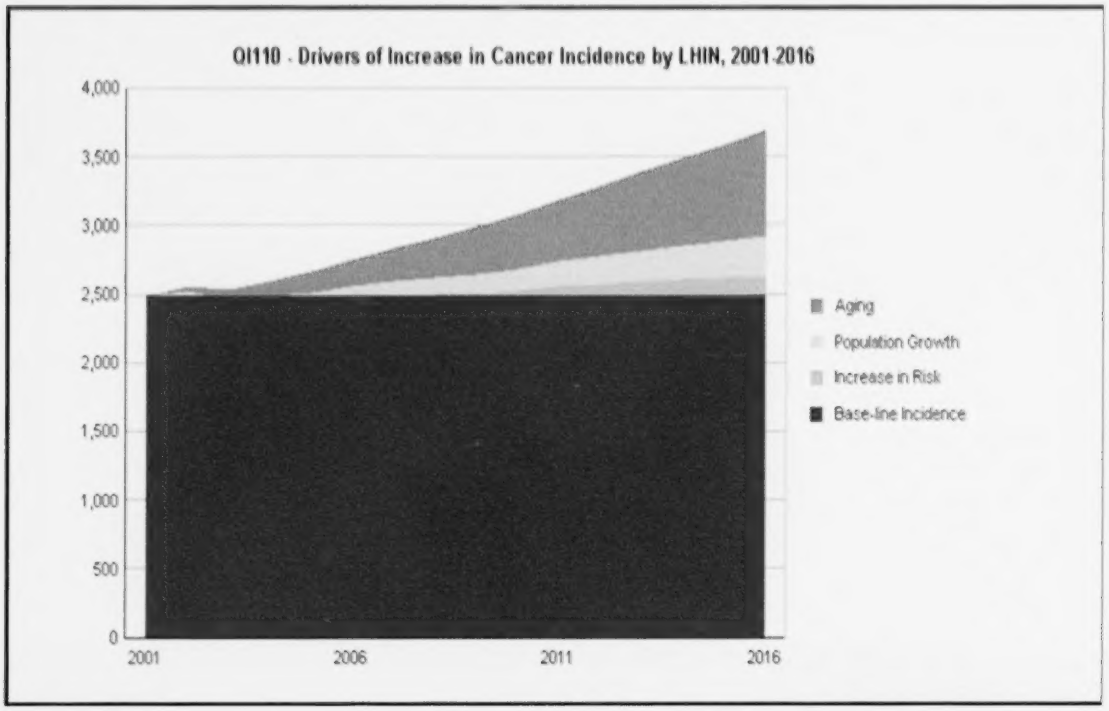
Health Indicator	Ontario Total / Average	South East	Comment
Health Practices, 2003 (and 2005, where available)			
% Population (age 12+) who are Daily Smokers (2005)	20.7%	24.2%	Upper Quartile
% of non-smokers regularly exposed to tobacco smoke at home (2005)	7.3%	9.9%	Upper Quartile
% of current drinkers who are 'Heavy Drinkers' (2005)	21.5%	25.2%	Upper Quartile
% Population consuming fruits & veg 5 or more times daily (2005)	41.0%	44.5%	Upper Quartile
% Population (age 12+) who are Physically Inactive (2005)	48.7%	46.6%	Lowest Quartile
% Population age 18+ who are Obese (2005)	15.1%	18.0%	
% Population age 18+ who are Overweight or Obese (2005)	48.5%	52.2%	
% Population age 18+ with a lot of life Stress (2005)	23.1%	20.2%	Lowest Quartile
% of passengers (age 12+) who always fasten their seatbelt	71.8%	79.8%	Upper Quartile
Preventive Care, 2003 (and 2005, where available)			
% of females age 50-69 who had mammogram in last 2 yrs (2005)	70.8%	67.3%	
% of females 50-69 with Screening mammogram in last 2 yrs (2005)	53.0%	47.2%	Lowest Quartile
% of females 18+ who had Pap test in last 3 years (2005)	72.9%	75.5%	Upper Quartile
% Population (age 12+) who have had flu shot in last year (2005)	41.1%	49.3%	Highest in Ontario
% of Population (age 12+) who have a Regular Medical Doctor (2005)	91.1%	90.9%	
% of Population (age 12+) who consulted an MD in the past year (2005)	81.5%	81.8%	
% Population (age 12+), who consulted at least 1 Health Professional in the past year	95.1%	94.9%	

3.3.3 Cancer

The incidence of new cancer cases is expected to increase steadily over the next 10 years. The exhibit following illustrates the expected increase in the South East LHIN area. The main contributor to cancer incidence will be the aging population. This is of significance for the South East LHIN because it has a higher than provincial average population of seniors.

[20] Ibid

Exhibit 3.7: Cancer Incidence 2001 – 2016



The anticipated increase in cancer incidence, coupled with improvements in cancer treatment, will result in annually increasing numbers of people living with cancer. The consequence will be a continued increased need for cancer services across the full spectrum both in the community and health care institutions.

3.3.4 Chronic Conditions

The reported prevalence of arthritis/rheumatism and heart disease in the SE LHIN area is the highest of all of the 14 LHINs.

The reported prevalence of chronic conditions for South East residents is significantly higher than the Ontario average for arthritis/rheumatism, high blood pressure, asthma, diabetes, heart disease, and for chronic bronchitis. The reported prevalence of arthritis/rheumatism and heart disease is the highest of all of the 14 LHINs.

The reported rates for prevalence of chronic conditions are not age-standardized, so regions with an older population (such as the South East LHIN area) will tend to have higher rates.

Also, as might be expected for a population with a higher prevalence of chronic disease, the rate of hospitalization for residents of the SE LHIN area is higher than the rest of the province.

The exhibit following shows the reported prevalence of chronic conditions (based on the 2005 Canadian Community

Health Survey) and rates of hospitalization for residents of the South East LHIN area.

Exhibit 3.8: Prevalence of Chronic Conditions and Rates of Hospitalization for SE Residents[21]

Health Indicator	Ontario Total / Average	South East	Comment
Prevalence of Chronic Conditions, 2003 (and 2005, where available)			
% of Population (age 12+) with Arthritis/rheumatism (2005)	17.1%	22.8%	Upper Quartile
% of Population (age 12+) with High Blood Pressure (2005)	15.2%	19.1%	Upper Quartile
% of Population (age 12+) with Asthma (2005)	8.0%	11.2%	Upper Quartile
% of Population (age 12+) with Diabetes (2005)	4.8%	6.0%	Upper Quartile
% of Population (age 30+) with Heart Disease	7.2%	10.1%	Highest in Ontario
% of Population (age 12+) with Chronic Bronchitis	2.7%	3.0%	Upper Quartile
Morbidity: Hospitalizations			
Crude hospitalization rate per 100,000 (2003/04)	8,003.0	8,994.2	
Age-standardized hospitalization rate per 100,000	7,746.7	8,108.8	
Age standardized Hospitalization Rates by ICD-10 chapter (top 5 chapters), rate per 100,000 (2003/04)			
Maternal conditions	1,367.8	1,326.8	
Circulatory system diseases	1,007.5	1,123.6	
Digestive system diseases	761.2	786.1	
Respiratory system diseases	624.6	700.9	
Injury & poisoning	578.6	662.1	

3.3.5 *First Nations Population*

Canadian studies have consistently shown that First Nations populations have reduced life expectancy and poor health status compared to the general Canadian population.

While the MOHLTC data shows that 2.0% of South East residents describe themselves as having Aboriginal identity, due to the non-completion of census forms by many on-reserve residents, the number of First Nations residents of the South East is under-estimated in the census data from which this figure was derived. The Tyendinaga Mohawk Territory was one of the 30 reserves in Canada that did not participate in the 2001 census. Statistics Canada has subsequently estimated that there were approximately 1,390 residents of the Tyendinaga reserve in 2001.

While data describing health service utilization and health care outcomes specifically for the First Nations residents of the South East LHIN area are not available, Canadian studies of First Nations health care have consistently shown that First Nations populations have reduced life expectancy and poor health status compared to the general Canadian population.

Health Canada's report on the health profile of First Nations residents of Canada[22] found that:

[21] Ibid

[22] Health Canada, "A Statistical Profile on the Health of First Nations in Canada for the Year 2000"

- Life expectancy at birth for the Registered Indian population was estimated to be 7.4 years less for males and 5.2 years less for females compared to the overall Canadian population's life expectancies
- In 2000, the infant mortality rate for First Nation people was 6.4 deaths per 1,000 live births -- 16% higher than the Canadian rate of 5.5. The First Nations rate has been falling steadily since 1979, when it was 27.6 deaths per 1,000 live births
- Combined, circulatory diseases (23% of all deaths) and injury (22%) account for nearly half of all mortality among First Nations. In Canada, circulatory diseases account for 37% of all deaths, followed by cancer (27%). Unintentional injury and suicide were approximately 6% of all deaths among First Nations in Canada
- The most common causes of death for First Nation people aged 1 to 44 years was injury and poisoning. Among children under 10 years, deaths were primarily classified as unintentional (accidental). For First Nations aged 45 years and older, circulatory disease was the most common cause of death
- In First Nations, potential years of life lost from injury was more than all other causes of death combined and was almost 3.5 times that of the Canadian rate
- The coverage rates for routine immunizations of 2 year-olds were lower among First Nations children for all antigens
- First Nation people's hospitalization rates were higher than the Canadian rates for all causes except circulatory diseases and cancers. Where the principal diagnoses were respiratory diseases, digestive diseases, or injuries and poisonings, the rates were approximately two to three times higher than their corresponding Canadian rates
- The 1997 First Nations smoking rate was reported to be 62%. In Canada, 24% of the population aged 15 years and older were smokers in 2000

Access to primary and community health care services for First Nation population is often limited by cultural barriers and the unavailability of local services.

Access to primary and community health care services for First Nation population is often limited by unavailability of local services and cultural barriers. This leads to reduced use of primary and preventive care, and greater reliance on hospitals for acute care. Recent analysis of patterns of hospital utilization in Saskatchewan found that:

- Rates of inpatient admission of the Registered Indian population were more than three times higher than the

general population for medical care and almost double the general population for surgical care

- Registered Indians were less likely to have medical and surgical procedures performed on an ambulatory basis
- Inpatient mental health admissions were 40% higher per population for the Registered Indian population

It will be important to determine the health status of the aboriginal populations in the South East LHIN and their needs for health services.

3.3.6 Francophone Population

There are communities within the South East LHIN with a large and active Francophone population.

A lower percentage of residents of the South East are Francophone (i.e., report French as their mother tongue) compared to the province as a whole. However, there are communities within the South East LHIN area with a large and active Francophone population. In May 2006, Kingston was designated as having a French language community under the French Language Services Act. As a result, all government offices, i.e. ministries and agencies, located in Kingston will offer French-language services effective May 1, 2009.

Francophones in the South East LHIN area are supported by ACFO (Association canadienne-francaise de l'Ontario) Mille-Îles, a non-profit organization that fosters the development and vitality of the Francophone community in the Thousand Islands region. ACFO Mille-Îles represents more than 11,000 Francophones living in the region between Trenton in the west and Brockville in the East.

Lack of access to French language services in the South East LHIN area is affecting the quality of health services and health of francophone residents.

One priority issue for the ACFO Mille-Îles is to ensure that the Francophone population has local access to French language health care and social service resources.

An inventory of French language resources in the Kingston area was produced by AFCO Mille-Îles in 2004.[23] The study found that:

- Availability and access to French language services for the local population was dismal, and the services that do exist are difficult to find
- When available, they must be explicitly requested in order to be accessed. In 79 % (or four out of five) cases, persons

[23] Research on the Availability of French Language Resources in the Sectors of Health and Social Services in the Kingston Region, Nov 2004, Association canadienne-française de l'Ontario (ACFO) Conseil régional des Mille-Îles

must explicitly request French language services in order for arrangements be made with the available personnel or volunteers

- 50 % of respondents claim to have bilingual personnel, but a large proportion of the bilingual individuals were not hired on the basis of bilingualism criteria (and it is luck of the draw that makes French language services available to the public)

Obstacles to offering French language services were described as:

- Need for French language services has not been documented (54 %)
- Lack of funds (28 %), and
- No bilingual employees (25 %)

A 2001 report by the Federation des Communautes Francophones et Acadienne du Canada[24] found that lack of availability of French-language health care services:

- Reduces the probability of using health services for preventive reasons
- Increases consultation time and use of diagnostic tests, and increases probability of error in diagnosis and treatment
- Impacts the quality of care, reduces the probability of compliance with treatment, and reduces satisfaction with care and services

A more recent study[25] by the Laurentian University Franco-Ontarian Institute and the Sudbury & District Public Health Unit found, among other things, that:

- Francophones perceive their own health as not being as good as that of the general population of Ontario
- There is no significant difference between Francophones and the whole population of Ontario in the rates of chronic diseases

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[24] "Improving Access to French-Language Health Services", Study Coordinated by the Federation des Communautes Francophones et Acadienne (FCFA) du Canada for the Consultative Committee for French-Speaking Minority Communities, June 2001.

[25] "Second Report on the Health of Francophones in Ontario", Franco Ontarian Institute of Laurentian University and Ontario Public Health Research, Education and Development Program at the Sudbury and District Health Unit, December, 2005.

The findings of these three studies suggest that lack of access to French language services in the South East LHIN is affecting the quality of health services and health of francophone residents.

3.4 Utilization of Health Services

Population statistics have been matched to utilization data to determine the current rate of utilization of health services by the overall population resident within the LHIN boundaries and the geographies and special populations within the LHIN. These utilization statistics along with socio-economic and health status indicators provide the basis for attempting to understand and measure population need for health services.

3.4.1 Primary Health Care Utilization

The large percentage of the population that is elderly in the South East LHIN area suggests a need for relatively more primary health care capacity.

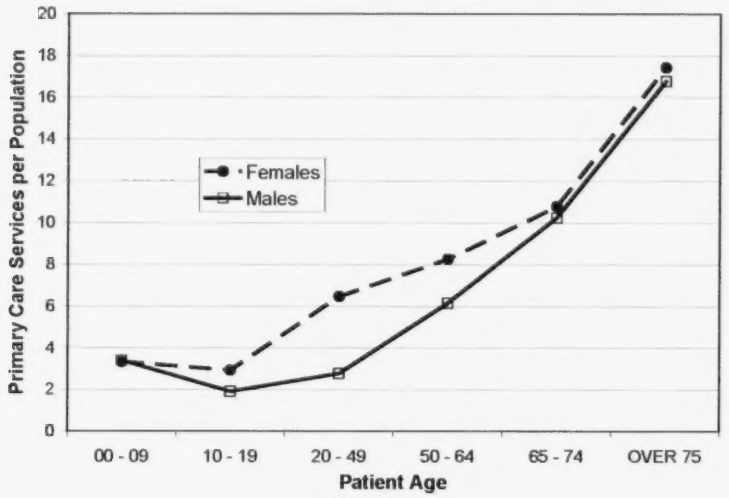
Primary health care can be defined as a set of first level services that promote health, prevent disease, and provide diagnostic, maintenance, curative, rehabilitative, supportive and palliative services.[26]

The exhibit following shows the count of average fee for service primary health care services provided by physicians per person by patient age and gender for South East LHIN area residents[27]. As can be seen, the average number of primary health care services per person increases considerably with patient age. As a result the large number of elderly in the South East LHIN area suggests a need for more primary health care capacity.

[26] Lamarche, P., Beaulieu, M., Pineault, R., Contandriopoulos, A., Denis, J. & Haggerty, J. *Choices for Change: The Path for Restructuring Primary Healthcare Services in Canada.* Canadian Health Services Research Foundation. (November, 2005).

[27] Data on primary care services provided by other health care professionals are unavailable at this time.

Exhibit 3.9: Primary Care Services per Person for South East LHIN Area Residents by Patient Age and Gender[28]

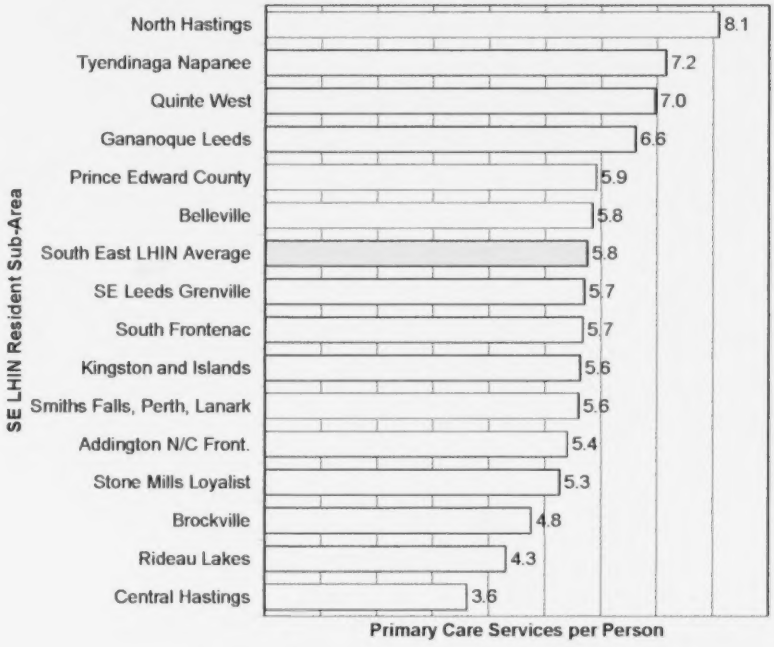


On average, residents of the South East LHIN used 5.8 fee-for-service physician primary health care services per person in 2004/05. The highest utilization of primary care was by the residents in North Hastings, Tyendinaga Napanee, and Quinte West. The lowest utilization of primary care was by the residents of Central Hastings, Rideau Lakes, and Brockville. It is important to note that these statistics may be misleading because they are based on fee-for-service payments to primary care physicians and as a result visits to primary care physicians practicing in Community Health Centres or who are participants in the Southeastern Ontario Academic Medical Organization[29] (SEAMO) are not included.

[28] 2004/05 MOHLTC OHIP primary care fee for service database, summaries provided by LHIN IM Support Group.

[29] SEAMO participates in an Alternate Funding Plan that provides a single negotiated monthly payment from the Ministry of Health and Long-Term Care to replace previous physician fee-for-service billings and several other funding streams. The agreement encompasses the mission of the Faculty of Medicine to include the clinical services provided by its members, the education of future physicians, and the faculty members' participation in the education of other health professionals, and research and scholarship. Approximately 200 full-time and 15 part-time medical faculty at Queen's University are remunerated under the SEAMO Agreement.

Exhibit 3.10: Age/Gender Standardized[30] Physician Services per Population by South East LHIN Sub-Area



3.4.1.1 Location of Primary Care Physicians

The exhibit following compares the patient location and the location of the primary care physician.[31]

89% of primary care physician services used by residents of the SE LHIN area are provided by physicians located within the LHIN.

62% of the primary care services used by South East LHIN area residents are provided by physicians located in the same sub-area where the patients live. A further 27% are provided by physicians located elsewhere in the South East LHIN area. 11% of primary care services for South East LHIN area residents are provided by physicians located outside the South East LHIN area.

[30] Age-Gender Standardized rate is an adjusted rate that represents what the crude rate would have been in the study population (e.g. the South East LHIN) if that population had the same age and gender distribution as the standard population. The standard population used in this report is the Ontario 2004 population. Age-gender standardized rates can be compared across LHINs.

[31] Primary care physician location is based on the physician billing address, which is not necessarily the location where care was provided.

Residents of South Frontenac, Rideau Lakes and Stone Mills Loyalist are most likely to travel elsewhere in the South East LHIN to access physician primary care.

Residents of Kingston, Belleville, and Brockville are most likely to receive their primary care services from a physician located in their community. Residents of South Frontenac, Rideau Lakes and Stone Mills Loyalist are most likely to travel elsewhere in the South East LHIN to access physician primary care. Residents of South East Leeds Grenville, North Hastings, and Central Hastings, are most likely to travel outside the South East LHIN for primary care.

Exhibit 3.11: Percent of 2004/05 Primary Care Physician Services for Residents of South East LHIN Sub-Areas Provided by Physician Location

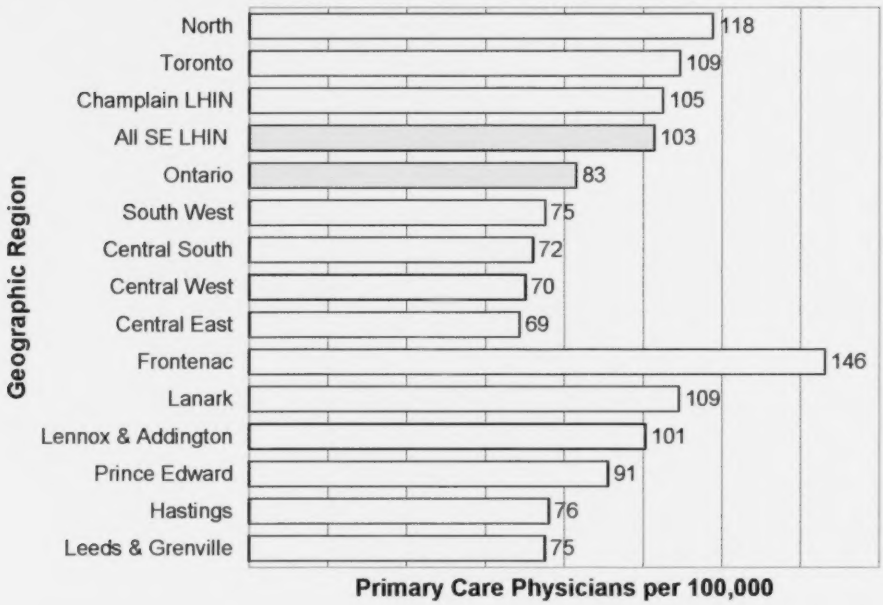
Patient Sub-Area	Primary Care Provider Location		
	In Same Sub-Area	Elsewhere in SE LHIN	Outside SE LHIN
Addington N/C Front.	43%	44%	13%
Belleville	71%	19%	10%
Brockville	70%	19%	11%
Central Hastings	27%	52%	21%
Gananoque Leeds	64%	32%	5%
Kingston and Islands	83%	11%	6%
North Hastings	66%	7%	27%
Prince Edward County	54%	36%	10%
Quinte West	56%	31%	13%
Rideau Lakes	12%	74%	14%
SE Leeds Grenville	31%	39%	30%
Smiths Falls, Perth, Lanark	68%	12%	20%
South Frontenac	11%	83%	6%
Stone Mills Loyalist	29%	66%	5%
Tyendinaga Napanee	63%	31%	6%
Grand Total	62%	27%	11%

3.4.1.2 Primary Care Physician Supply

In 2004, the number of primary care physicians per 100,000 population in the South East LHIN area was 24% higher than the Ontario average of 83.

The Ontario Physician Human Resource Data Centre (OPHRDC) collects provincial data on physician supply by age and gender, geographic location, and specialty. The exhibit following shows the 2004 number of primary care physicians per 100,000 population for the counties in the South East LHIN area and for the MOHLTC planning regions. In 2004, there were 103 primary care physicians per 100,000 population in the South East LHIN area, 24% higher than the Ontario average of 83.

Exhibit 3.12: Primary Care Physicians per 100,000 Population by SE LHIN County and MOHLTC Planning Area, 2004[32][33]



An ICES study concluded that "when all adjustments are considered, the East's physician supply appears similar to the provincial average".

While the OPHRDC data suggests that the supply of primary care physicians in the South East is above the provincial average, there are limitations to this analysis:

- The calculations of physicians per population are based on crude rates, and don't take into account the older population in the South East LHIN
- Analysis of physician supply by Institute of Clinical Evaluative Sciences (ICES), based on 2001/02 data, found that while eastern Ontario [South East and Champlain LHINs] had a physician to population ratio well above the provincial average, the East had more physicians working part time than other regions, and more GPs who are functioning as "quasi-specialists". As a result, the ICES conclusion was that "when all adjustments are considered, the East's physician supply appears similar to the provincial average"[34]

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[32] Physicians in Ontario 2004, Ontario Physician Human Resource Data Centre. Data is available only at the county level and does not reflect the split of some counties between LHINs.

[33] These are referred to as "Non-Specialist Physicians" in Physicians in Ontario 2004, Ontario Physician Human Resource Data Centre.

[34] ICES Investigative Report, "Supply and Utilization of General Practitioner and Family Physician Services in Ontario", August 2005.

3.4.1.3 Ambulatory Care Sensitive Conditions

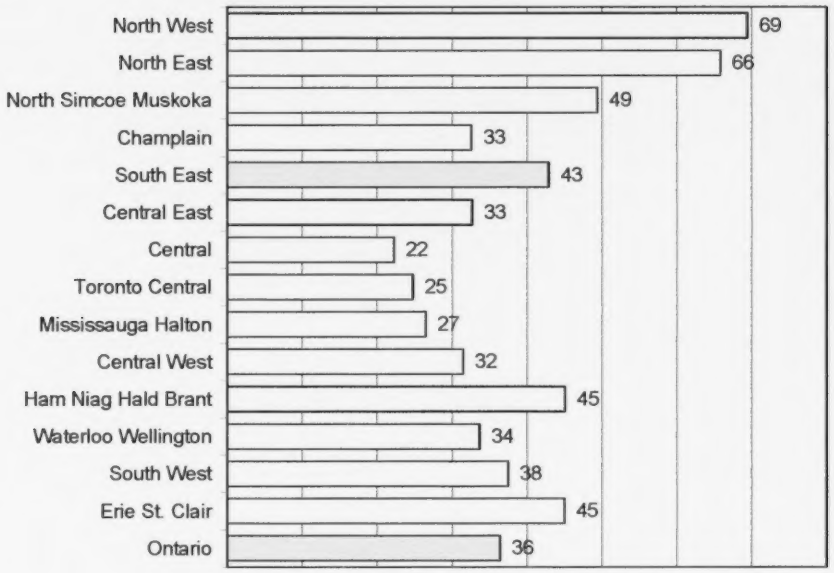
The Canadian Institute for Health Information (CIHI)[35] categorizes some inpatient admissions as "ambulatory care sensitive condition" admissions, meaning that if appropriate primary health care had been available, the inpatient admission of the patient could have been avoided, either because their condition would never become so serious as to require hospitalization, or because their care could be managed on an ambulatory basis. The conditions are:

- Pneumonia
- Congestive Heart Failure
- Asthma
- Cellulitis
- Ulcer
- Pyleonephritis
- Diabetes
- Ruptured Appendix
- Hypertension
- Hypokalemia
- Immunizable Conditions
- Gangrene

The rate of hospital admission of patients with these ambulatory care sensitive conditions for South East LHIN area residents is fourth highest among the 12 LHINs in southern Ontario. Improved primary health care in the South East LHIN area likely would help to reduce the rate of hospitalization for these conditions.

[35] CIHI, "Health Care in Canada", 2006.

Exhibit 3.13: 2004/05 "Ambulatory Care Sensitive Condition" Inpatient Discharges per 10,000 Age/Gender Standardized Population by Patient LHIN



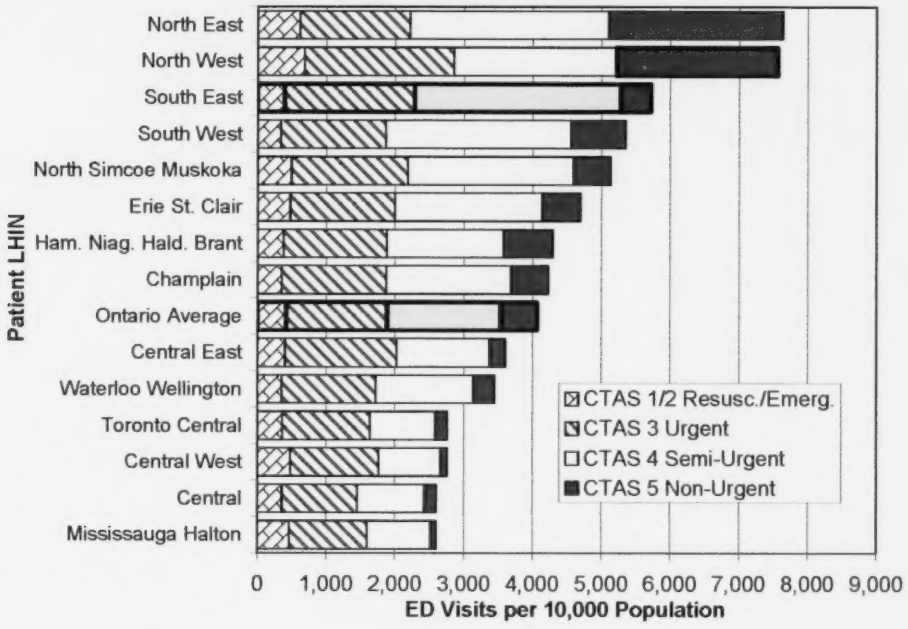
3.4.2 Hospital Emergency Department Utilization

Residents of the South East have the highest overall rate of utilization of ED visits per population of any of the southern Ontario LHINs.

Residents of the South East have the 3rd highest overall rate of utilization of Emergency Department (ED) visits per population, and the highest rate of any of the southern Ontario LHINs. The exhibit following presents the age/gender standardized ED utilization per population by LHIN (based on patient residence) according to the Canadian Triage Acuity Scale (CTAS) level. All Ontario hospitals are required to track their emergency department (ED) visits and to categorize each visit according to the Canadian Triage Acuity Scale (CTAS). The five CTAS levels are:

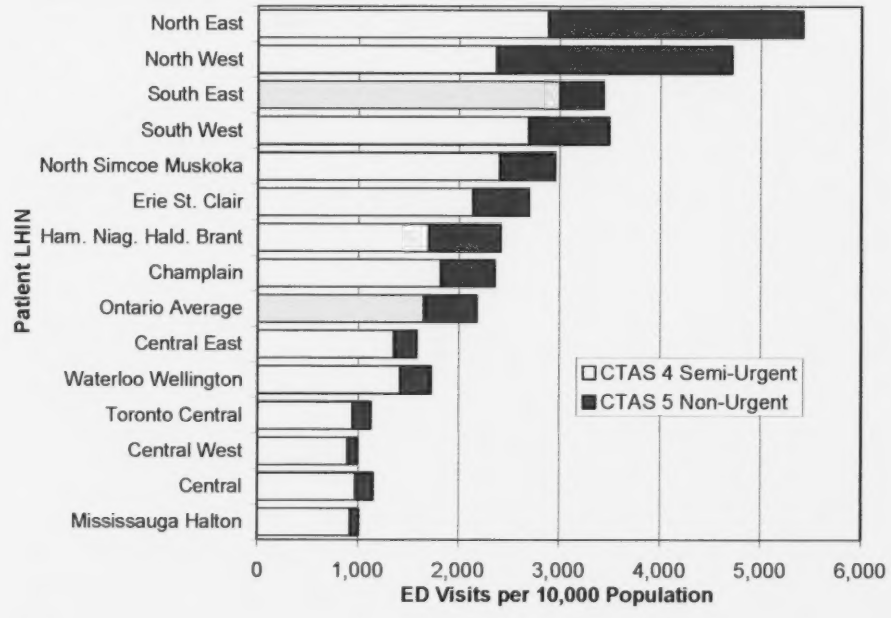
- CTAS 1 – Resuscitation
- CTAS 2 – Emergent
- CTAS 3 – Urgent
- CTAS 4 – Semi-Urgent
- CTAS 5 – Non-Urgent

Exhibit 3.14: 2004/05 Age/Gender Standardized ED Visits per 10,000 Population by Patient LHIN



Non-Urgent and Semi-Urgent care explain most of the difference in ED use by residents of the South East LHIN area compared to other southern Ontario LHINs. The exhibit following shows a comparison of ED utilization by LHIN for non-urgent and semi-urgent cases only.

Exhibit 3.15: 2004/05 Age/Gender Standardized Non-Urgent ED (CTAS 5) and Semi-Urgent (CTAS 4) Visits per 10,000 Population by Patient LHIN



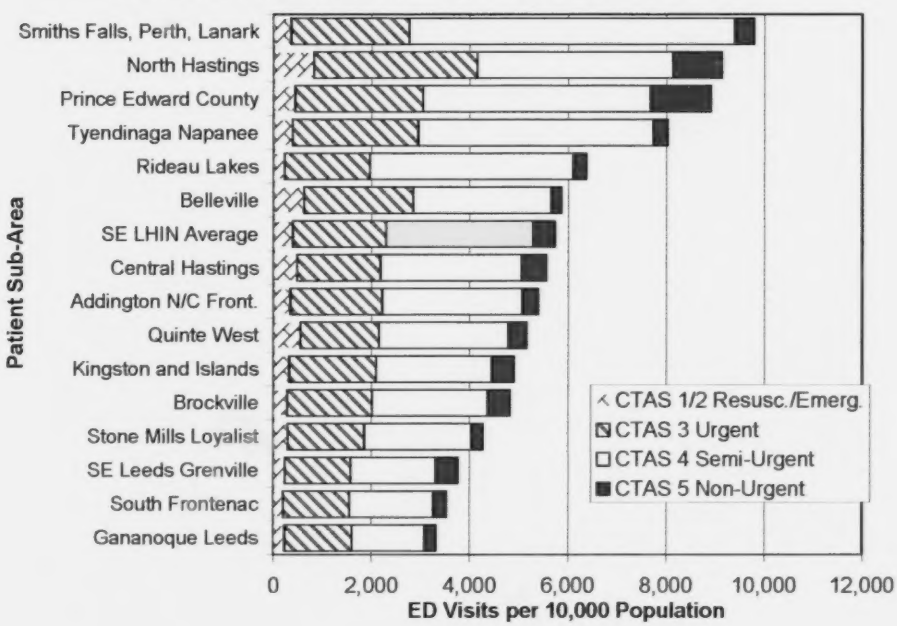
Enhancements in primary health care can lead to greater continuity of care for patients, and reduce both ED visits and inpatient hospitalization.

As can be seen, the rate of non and semi urgent visits to EDs in the South East LHIN area is the fourth highest in the province and is more than triple the rates in four of the Greater Toronto Area LHINs. The difference is explained by the rate of visits to the ED for semi-urgent (CTAS level 4) care. The South East semi-urgent ED visit rate is the highest in Ontario, 60% above the provincial average, and more than triple the rates in four of the Greater Toronto Area LHINs.

The high rate of non-urgent and semi-urgent ED visits in the South East suggests that there are opportunities to enhance availability and access to other community health services and thereby reduce reliance on the ED for care. Enhancements in primary health care can lead to greater continuity of care for patients, and reduce both ED visits and inpatient hospitalization. Although primary physician care is outside the direct scope of the LHINs (except for community health centres), clearly the requirements for LHIN related health services in the South East will be highly dependent on the capacity and organization of the primary health care system.

There are regional variations within the LHIN in the use of ED services. The lowest ED utilization rate is for residents of Gananoque Leeds and South Frontenac. Residents of Smiths Falls, Perth, and Lanark have the highest ED utilization rate. The exhibit following shows the analyses of ED utilization by the geographic sub-areas within the South East.

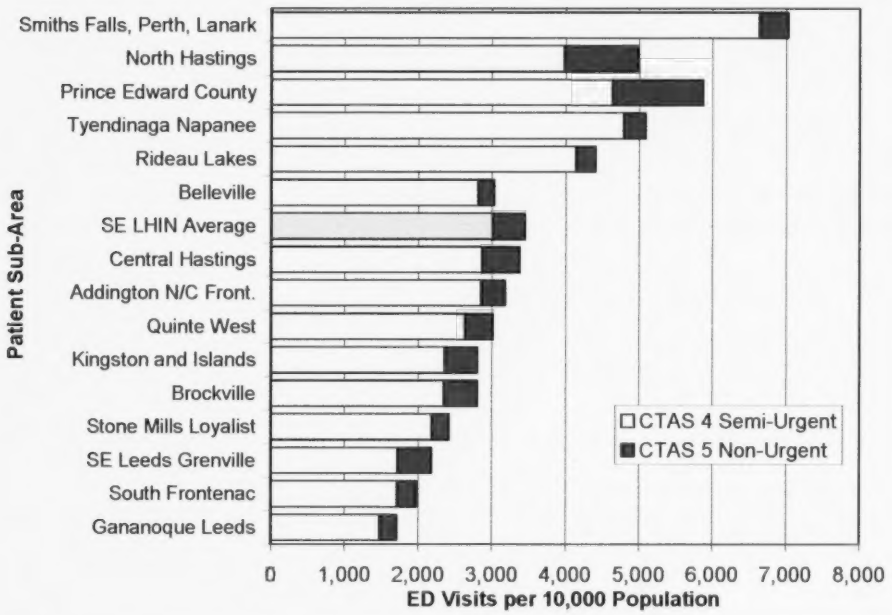
Exhibit 3.16: 2004/05 Age/Gender Standardized ED Visits per 10,000 Population by SE LHIN Patient Sub-Area



The rate of non-urgent ED visits for Perth, Smiths Falls and Lanark residents is more than three times the rate for Gananoque Leeds and South Frontenac residents.

Similarly, there is great variation in the use of EDs for semi-urgent and non-urgent care. The rate of non-urgent ED visits for Perth, Smiths Falls and Lanark residents is more than three times the rate for Gananoque Leeds and South Frontenac residents. The exhibit following shows the semi- and non-urgent ED visit rate by sub-area.

Exhibit 3.17: 2004/05 Age/Gender Standardized
Semi and Non-Urgent ED Visits per 10,000 Population
SE LHIN Patient Sub-Area



3.4.3 Acute Care Hospital Utilization

Two thirds of all MOHLTC base funding for LHIN related health care provider agencies in the South East is for hospital services.

Two thirds of all MOHLTC base funding for LHIN related health care provider agencies in the South East is for hospital services. The majority of this funding was used to provide inpatient acute care and ambulatory surgical procedures. Understanding how acute care hospital services are used by, and provided for, the residents of the South East, and the residents of other LHINs who rely on South East hospitals, will be important for the South East LHIN as it assesses integration priorities.

The data systems developed to track acute care hospital utilization are the most well developed of any sector. Acute care data can often be used to gain insights into impacts of shortfalls in the availability of primary medical care and other community-based services.

For these reasons, many of the analyses conducted for the South East LHIN environmental scan have focused on analyses of patterns of utilization of acute care.

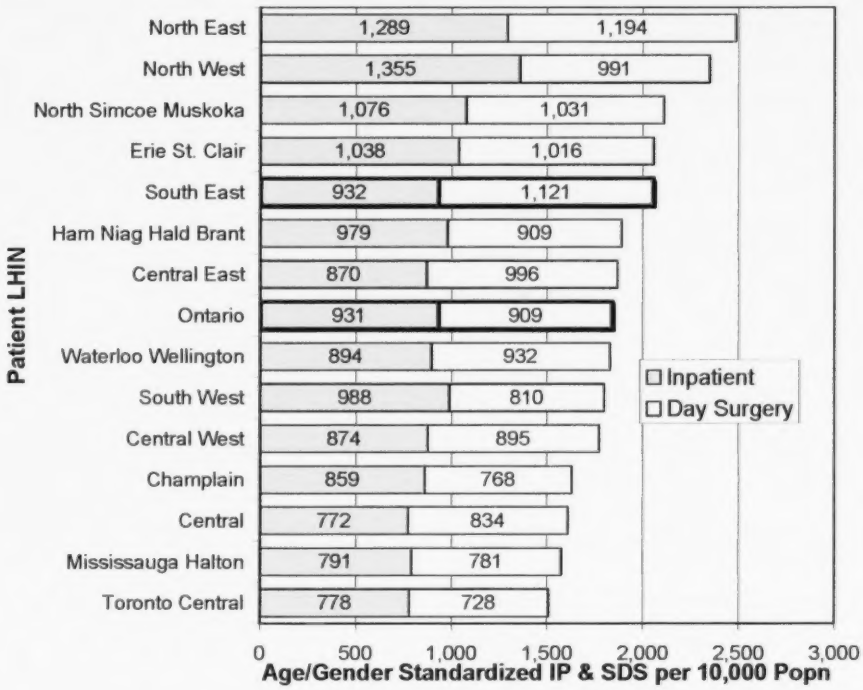
A basic measure of acute care utilization is the number of hospital separations (discharges) per 10,000 population, adjusting for the age and gender composition of the population. The process of adjusting utilization rates to take into account differences in the underlying demographic composition of the population is referred to as "standardization". Unless otherwise noted, all of the measures of acute care utilization shown in this chapter have been gender and age (using 5 year age cohorts) standardized.

Hospital utilization rate for the South East is 5th highest in the province and above the rates for other LHINs where the majority of acute care is provided by academic health science centres.

The exhibit following shows the 2004/05 combined inpatient and day surgery utilization rates measured as separations per 10,000 age/gender standardized population for the residents of each LHIN. This is the rate by which residents of a LHIN are admitted to hospital, regardless of location. The overall hospital utilization rate for residents of the South East LHIN area is 5th highest in the province and above the rates for all other LHINs where the majority of acute care is provided by academic health science centres[36]. Acute care utilization rates for regions served by academic health science centres are usually low; this is generally attributed to an emphasis on evidence-based practice (which leads to reduced inpatient admissions), the presence of complementary community health services and a robust primary health care system that allows reduced reliance on acute care.

[36] The SE LHIN is home to the South Eastern Ontario Health Science Centre. Other LHINs with an Academic Health Sciences Centre (AHSC) are Toronto Central, Champlain, South West, and Hamilton, Niagara, Haldimand Brant.

Exhibit 3.18: 2004/05 Same Day Surgery (SDS) and All Inpatient (IP) Discharges per 10,000 Age/Gender Standardized Population by Patient LHIN[37]



Higher rates of hospital utilization may reflect less availability of ambulatory and community services, and the resulting necessary reliance on inpatient acute care. To assess this impact on South East residents, we categorized the inpatient acute care activity by "level of care", to see whether the higher utilization was concentrated in the basic hospital services that can be avoided (to a greater extent) if a robust broader health system is available. Inpatient acute care cases were assigned to a level of care using the Hay Level of Care Assignment methodology[38], which categorizes each case as Primary[39], Secondary, or Tertiary/Quaternary, based on the patient age, the Case Mix Group, and the "complexity" of the case. An appendix to this IHSP provides a description of the Hay Level of Care methodology.

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[37] CIHI Discharge Abstract Database (DAD) and National Ambulatory Care Reporting System (NACRS), Ontario, 2004/05 and Ontario Ministry of Finance draft, unpublished 2004 population estimates by LHIN.

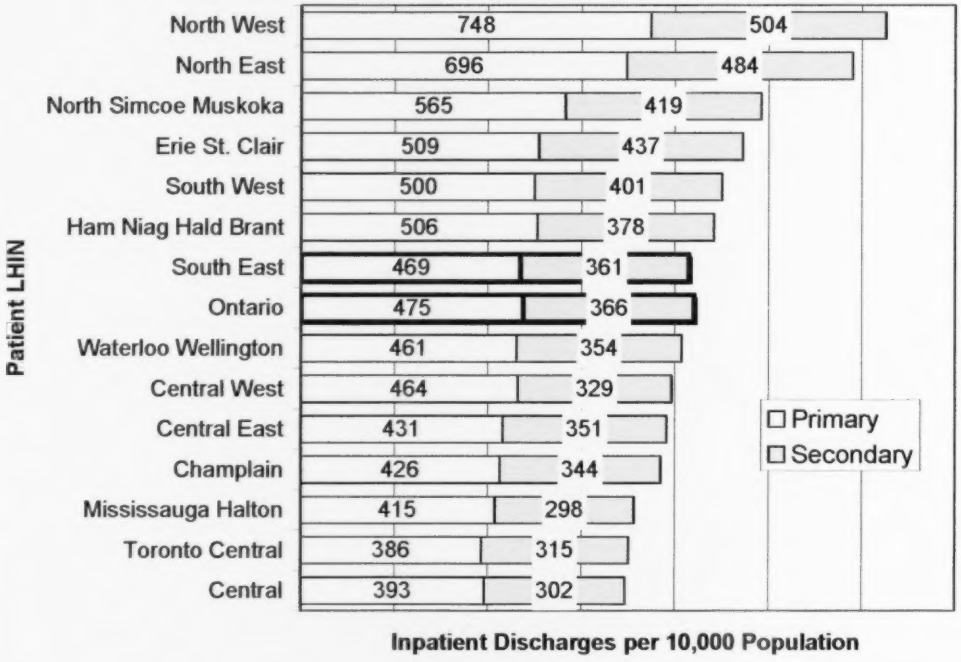
[38] A more detailed explanation of this methodology is provided in an appendix to the IHSP.

[39] The "Primary" category of the Hay Level of Care algorithm refers to basic inpatient hospital care (i.e. patient care that one would expect any acute care hospital to be able to provide) and should not be confused with community based primary care.

Utilization of primary and secondary level inpatient acute care by residents of the SE LHIN area is approximately equal to the provincial average.

It is interesting to note that South East residents have a rate of utilization of Primary and Secondary level inpatient acute care approximately equal to the provincial average. All acute care hospitals in the South East provide Primary level acute care services. All but the very smallest hospitals in the South East (i.e. those that do not offer inpatient surgery or obstetrics) provide Secondary level acute care. This would suggest that residents of the area are not using inpatient care to compensate for shortages of community services more than elsewhere in Ontario.

Exhibit 3.19: 2004/05 Primary and Secondary Inpatient Discharges per 10,000 Age/Gender Standardized Population by Patient LHIN[40]



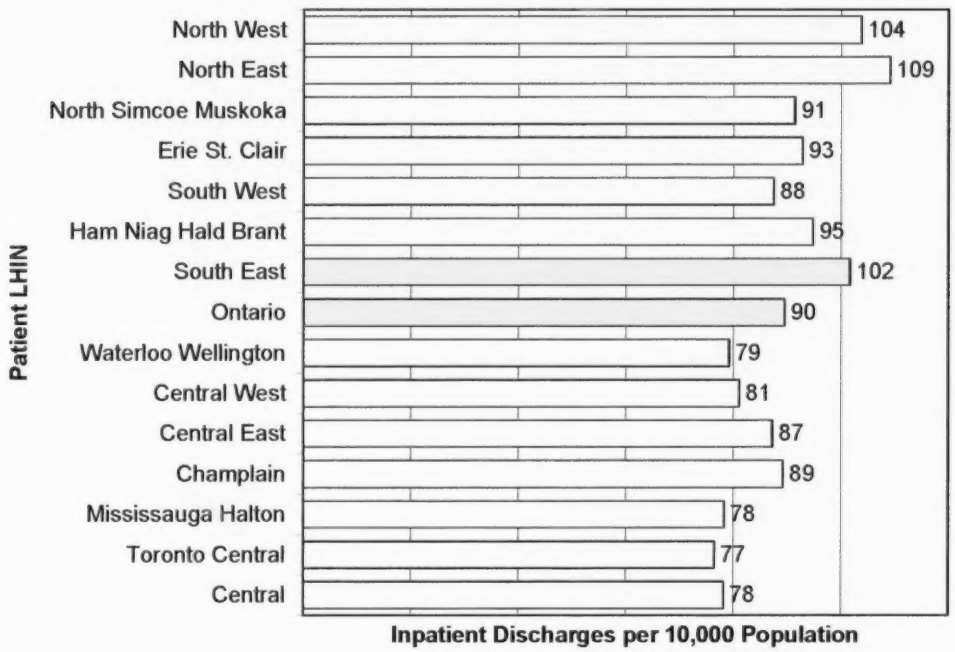
High use of tertiary inpatient acute care likely reflects the higher burden of illness in the South East LHIN area and the availability of services from the AHSC.

However, the rate of utilization of inpatient Tertiary/Quaternary acute care by South East LHIN area residents is the second highest in the province. This indicates that South East LHIN area residents have relatively good access to Tertiary/Quaternary services, likely due to the presence of the academic health science centre in Kingston, and the relatively low LHIN population (compared to the other LHINs served by Ontario's four other academic health science centres in Hamilton, Toronto, Ottawa, and London). It likely also reflects the relatively high burden of illness of the population of the South East LHIN area. The exhibit

[40] CIHI Discharge Abstract Database, Ontario, 2004/05 and Ontario Ministry of Finance draft, unpublished 2004 population estimates by LHIN.

following shows the utilization rates for Tertiary/Quaternary level of care inpatient hospitalizations by LHIN. Tertiary/Quaternary hospitalizations include complex medical patients, cardiac surgery and neurosurgery, and organ transplants. Tertiary/Quaternary acute hospital care is usually concentrated in academic health science centres (such as the Kingston acute care hospitals) or large regional acute care facilities.

Exhibit 3.20: 2004/05 Tertiary/Quaternary Inpatient Discharges per 10,000 Age/Gender Standardized Population by Patient LHIN[41]



The MOHLTC has developed "Patient Cluster Categories" (PCCs) that group together inpatient cases on the basis of the likelihood that their inpatient care would be managed by the same medical specialty or subspecialty. The table in the Exhibit following shows the Ontario and South East LHIN area resident age/gender standardized acute care inpatient utilization rates for each individual PCC. The comment column describes how the South East LHIN area resident rate compares to the distribution of rates for all 14 LHINs.

The PCCs for which the South East LHIN area resident inpatient acute care utilization is in the highest quartile in Ontario are:

[41] CIHI Discharge Abstract Database, Ontario, 2004/05 and Ontario Ministry of Finance draft, unpublished 2004 population estimates by LHIN.

- Pulmonary
- Cardio/Thoracic
- Neurosurgery

The PCCs for which the South East LHIN area resident inpatient acute care utilization rate is in the lowest quartile in Ontario are:

- General Surgery
- Otolaryngology (lowest in Ontario)
- Plastic Surgery
- Not Generally Hospitalized (lowest in Ontario)
- Ophthalmology
- Dermatology
- Dental/Oral Surgery

In the consultation sessions it was reported that there is currently a shortage of plastic surgeons and dermatologists in the SE LHIN area. The shortage is likely the major cause of low rates for these types of inpatient hospitalizations.

Also, any of the PCCs where the South East LHIN area inpatient acute care utilization rates are low are services where it is possible to provide care on an ambulatory basis via day surgery (e.g. otolaryngology, plastic surgery, ophthalmology, dermatology, dental/oral surgery). As is seen in Exhibit 3.16, residents of the SE LHIN area have a relatively high rate of use of ambulatory surgery (2nd highest in the province) which may explain the low rate of admission for these types of cases.

Exhibit 3.21: 2004/05 Inpatient Discharges per 10,000 Age/Gender Standardized Population by Patient Cluster Category [42]

Patient Cluster Category	Ontario Average	SE LHIN Rate	Comment re SE LHIN Rate
Total Inpatient	928.4	930.8	
Obstetrics	126.0	121.6	
Neonatology	117.5	112.2	
Cardiology	86.0	88.0	
General Surgery	68.6	59.0	Lowest Quartile
Gastro/Hepatobiliary	64.2	64.0	
Pulmonary	61.6	69.1	Highest Quartile
Psychiatry	55.1	59.2	
Orthopaedics	49.0	56.1	
General Medicine	47.6	46.1	
Trauma	37.6	40.3	
Cardio/ Thoracic	31.3	41.4	Highest Quartile
Urology	31.1	30.2	
Neurology	27.4	29.0	
Oncology	27.2	27.1	
Gynaecology	25.6	24.5	
Endocrinology	14.6	15.3	
Otolaryngology	13.7	8.7	Lowest in Ontario
Haematology	8.4	7.8	
Nephrology	7.9	7.3	
Vascular Surgery	6.9	6.7	
Neurosurgery	5.4	6.3	Highest Quartile
Plastic Surgery	3.6	2.2	Lowest Quartile
Not Generally Hosp.	3.3	1.6	Lowest in Ontario
Rheumatology	2.6	2.5	
Ophthalmology	2.5	1.6	Lowest Quartile
Rehabilitation	2.1	1.4	
Dermatology	1.5	1.1	Lowest Quartile
Dental/Oral Surgery	0.3	0.2	Lowest Quartile
Ungroupable	0.1	0.1	

Residents of the South East LHIN area rely on hospitals within the LHIN for 89% of their inpatient acute care hospitalizations.

Not all South East LHIN area residents obtain their acute hospital care in a hospital located in their local community. Many South East LHIN communities do not have local access to an acute care hospital, and some of the smaller acute care hospitals do not have the full range of services that would be necessary to meet all of their community's needs. The exhibit following shows the percent of inpatient care used by the residents of selected South East LHIN geographies and overall provided by each South East (and other Ontario) hospital.

[42] CIHI Discharge Abstract Database, Ontario, 2004/05 and Ontario Ministry of Finance draft, unpublished 2004 population estimates by LHIN.

Exhibit 3.22: Percent of Inpatient Acute Care for Residents of SE LHIN Sub-Area Provided by Each Hospital[43,44,45]

Acute Care Hospital	% of Total Hospitalizations of Residents Provided by Individual Acute Care Hospital or LHIN															
	Addington N/C Front.	Belleville	Brockville	Central Hastings	Gananoque Leeds	Kingston and Islands	North Hastings	Prince Edward County	Quinte West	Rideau Lakes	SE Leeds Grenville	Smiths Falls, Perth, Lanark	South Frontenac	Stone Mills Loyalist	Tyendinaga Napanee	All South East LHIN
Brockville General Hospital			67%		11%					8%	62%					10%
Hotel Dieu Hospital-Kingston	3%				2%	6%				1%			3%	3%	3%	2%
Kingston General Hospital	43%	13%	16%	14%	78%	88%	10%	17%	16%	31%	10%	7%	92%	80%	39%	38%
Lennox And Addington County Gen Hos	8%			1%										12%	40%	3%
Perth & Smiths Falls Dist-Perth Sit	10%									14%		22%				2%
Perth & Smiths Falls Dist-Smiths Fa	2%		3%							34%		37%				4%
Providence Continuing Care Ctr-King						1%										
Quinte Healthcare Corporation-Bancr							22%									
Quinte Healthcare Corporation-Belle	9%	78%		60%			29%	30%	43%						13%	21%
Quinte Healthcare Corporation-Picto								43%								3%
Quinte Healthcare Corporation-Trent		2%		2%				4%	32%							4%
Royal Ottawa Hlth Care Grp-Brockvil			5%		2%					1%	2%	2%				
Champlain LHIN	7%		7%		2%	1%	5%			9%	24%	28%		1%		5%
Central East LHIN	1%			15%			25%		4%							2%
Toronto Central LHIN	12%	3%		4%	1%	1%	5%	3%	3%						1%	2%
Central LHIN							1%									
South West LHIN	2%				1%											
Waterloo Wellington LHIN																
Mississauga Halton LHIN																
Ham. Niag. Hald. Brant LHIN																
North East LHIN																
Central West LHIN																
North Simcoe Muskoka LHIN																
Erie St. Clair LHIN																
North West LHIN																
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
All SE LHIN Hospitals	76%	95%	91%	79%	94%	96%	62%	95%	91%	89%	75%	70%	96%	96%	96%	89%
Outside SE LHIN	24%	5%	9%	21%	6%	4%	38%	5%	9%	11%	25%	30%	4%	4%	4%	11%

As can be seen, overall, residents of the South East LHIN area rely on hospitals within the LHIN for 89% of their inpatient acute care hospitalizations. Kingston General provides 38% of inpatient acute care, Quinte Healthcare-Belleville provides 21% and Brockville General Hospital provides 10%. Together, the residents of the South East rely on these three hospitals to provide almost 70% of their inpatient hospital care. The remaining hospitals within the LHIN area provide only 20% of the inpatient hospital care used by residents of the LHIN. Hospitals outside the LHIN area provided 11% of the inpatient hospital care (5,390 admissions) used by residents of the SE LHIN area.

Residents of the SE LHIN area get most of their hospital care from SE LHIN hospitals

When compared to other LHINs, hospitals within the SE LHIN area provide a relatively high proportion of the hospital care used by residents of the LHIN. The exhibit following compares the percentage of hospital care for residents of each LHIN that is provided by hospitals located within the LHIN.

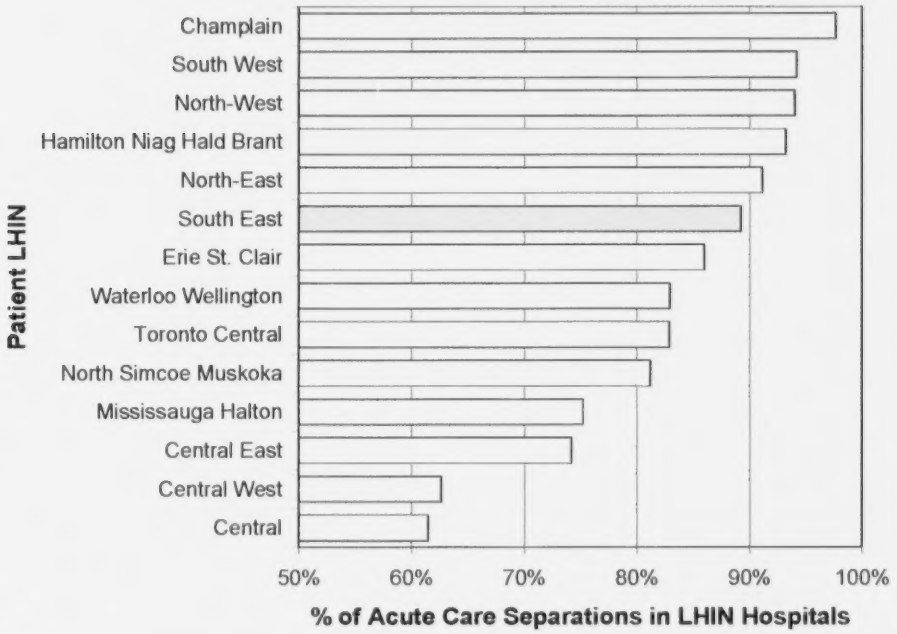
[43] CIHI Discharge Abstract Database (DAD), Ontario, 2004/05.

[44] Note that rows and columns may not sum due to rounding of cell entries.

[45] Blank cells are either 0 or less than 0.5%.

As can be seen, the percentage of SE LHIN area residents' inpatient hospital care provided by hospitals within the LHIN is 6th highest of all the LHINs in the province.

Exhibit 3.23: Percentage of Residents' Inpatient Hospital Care Provided by Hospitals within the LHIN.



Looking at the utilization of hospitals by level of care, we find that residents of the LHIN use hospitals within the LHIN for:

- 93% of their Primary Acute Care Inpatient Hospitalizations
- 88% of their Secondary Acute Care Inpatient Hospitalizations
- 78% of the Tertiary/Quaternary Acute Care Inpatient Hospitalizations

As would be expected, we find that residents of the LHIN area use hospitals within the LHIN for almost all of their primary and secondary hospital care and for most of their tertiary care. Because the SE LHIN area is home to the Academic Health Sciences Centre (AHSC) in Kingston, the percentage of tertiary care provided by hospitals within the SE LHIN is likely higher than in LHINs that do not contain an AHSC.

Also, SE LHIN hospitals provide 2,720 admissions for patients from outside the SE LHIN area. These admissions accounted for 6.2% of all the inpatient hospitalizations provided by SE LHIN area hospitals. Again, many of these patients are likely referrals for tertiary care to the AHSC in Kingston.[46,47]

3.4.4 Cancer Care

The Cancer Quality Council of Ontario published 23 Cancer Quality Performance Indicators in April 2005. Cancer Care Ontario targeted 13 of the indicators as priorities for 2005/06 and published results for these indicators in April 2006. When considering the 13 indicators, which only provide a snapshot of the cancer system, providers in the SE LHIN perform well from a patient care perspective in the domains of: patient satisfaction, use of evidence-based treatment guidelines for radiation and systemic therapy, 30-day post cancer surgery mortality, wait times for systemic therapy and the comprehensiveness of pathology reporting. Providers in the SE LHIN do not perform so well against provincial targets for: Fecal Occult Blood Test (FOBT) colorectal cancer screening, breast screening mammography, wait times for breast cancer assessment, radiation treatment and cancer surgery, coordination of care, and access to palliative and supportive care services. In the area of prevention, there are higher smoking and obesity rates than the provincial average. Smoking and diet are known to be important risk factors for a number of cancers. Although they are not comprehensive, the Continuous Quality Indicators (CQI) suggest that providers in the SE LHIN should focus on improving disease prevention, access and coordination related to cancer services.

3.4.5 Alternate Level of Care (ALC) Days

The ALC rate for South East LHIN residents is the highest of any of the LHINs outside northern Ontario.

The utilization analyses above focused on acute care hospital discharges per population as the measure of acute care hospital utilization. A challenge faced by many Ontario acute care hospitals is that their acute care beds are often occupied by patients who no longer require the type of care available only

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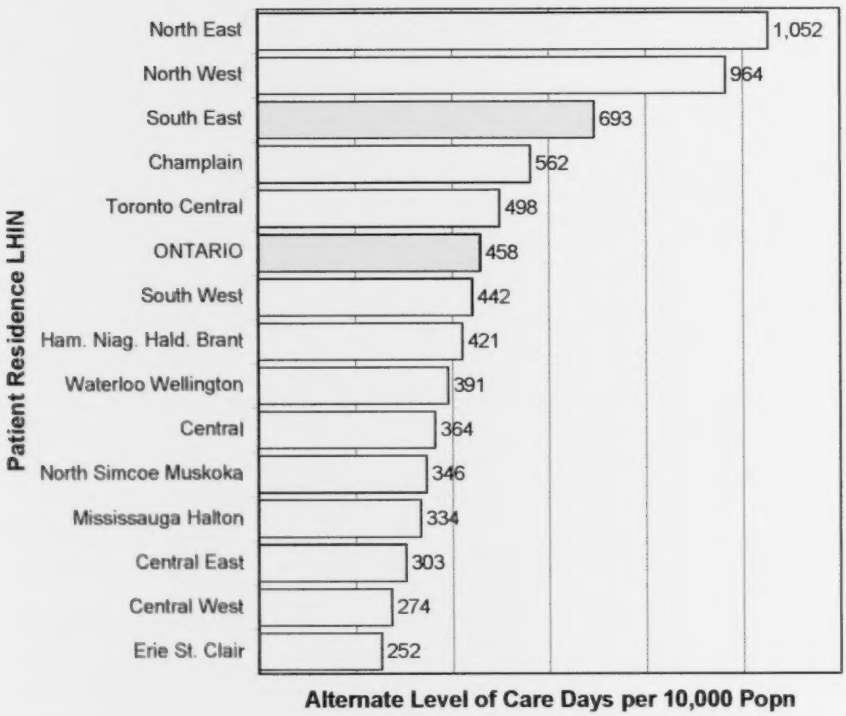
[46] When compared with the 5,390 admissions of SE LHIN residents to hospitals outside the SE LHIN, this means that the SE LHIN is a net exporter of residents for hospital care.

[47] A portion of these admissions relate to the support provided by the Queen's Weeneebayko Program to the Aboriginal communities in North Eastern Ontario (LHIN 9). Within this program Queen's clinicians go to Aboriginal communities in the North East and in serious cases fly patients to KGH or HDH for care. Support for these communities adds to the demands placed on limited health care resources in the South East LHIN.

in an acute care hospital, but these patients can't be discharged because there is no place for them in an alternative care environment (such as complex continuing care, long term care home, home with appropriate home care services, etc.). Approximately 10% of all patient days in Ontario acute care hospitals are reportedly used by non-acute patients waiting for discharge or placement. The days these patients spend waiting are referred to as "alternate level of care" (ALC) days.

The exhibit following shows the age/gender standardized rate of ALC days per 10,000 population by LHIN. The rate for South East LHIN area residents is the 3rd highest of all LHINs, and the highest of any of the LHINs outside northern Ontario.

Exhibit 3.24: 2004/05 Age/Gender Standardized Alternate Level of Care Days per 10,000 Population by LHIN[48]



Almost 60% of patient days spent waiting for an alternate level of care are waiting for some form of residential long-term care.

Almost 47% of ALC patient days in South Eastern Ontario hospitals are used by patients who are discharged to long-term care homes. A further 13% are used by patients discharged to Complex Continuing Care (Chronic Care Facility). Taken together, almost 60% of patient days spent waiting in hospital for an alternate level of care are waiting for some form of

[48] CIHI Discharge Abstract Database (DAD), Ontario, 2004/05 and Ontario Ministry of Finance draft, unpublished 2004 population estimates by LHIN.

residential long-term care.[49] Conversely, a relatively smaller number of patient days are spent waiting for discharge to inpatient rehabilitation, home care and transfer to another acute care facility.

Exhibit 3.25 Discharge Disposition and ALC Patient Days of SE LHIN Area Patients Waiting in Acute Care for an Alternate Level of Care

Discharge Disposition	IP Cases	% of All Cases	IP Days	Avg. LOS	ALC Days	% ALC	Avg. ALC per Case	% of All ALC Days
LTC (NH/HFA)	2,051	3.5%	51,107	24.9	21,498	42.1%	10.5	46.8%
Chronic Care Facility	956	1.6%	16,111	16.9	6,033	37.4%	6.3	13.1%
Died	2,528	4.3%	78,774	31.2	5,896	7.5%	2.3	12.8%
Other	799	1.3%	20,597	25.8	3,054	14.8%	3.8	6.7%
Home (No Home Care)	43,454	73.2%	224,574	5.2	3,041	1.4%	0.1	6.6%
Rehab	939	1.6%	14,617	15.6	2,736	18.7%	2.9	6.0%
Home Care	5,651	9.5%	83,051	14.7	2,470	3.0%	0.4	5.4%
Acute Care	2,986	5.0%	30,428	10.2	1,161	3.8%	0.4	2.5%
Grand Total	59,364	100.0%	519,259	8.7	45,889	8.8%	0.8	100.0%

3.4.6 *Utilization of Inpatient Rehabilitation*

In addition to acute inpatient care, Ontario hospitals also provide inpatient hospital care in rehabilitation and complex continuing care beds.

Utilization of inpatient rehabilitation beds in SE LHIN area is 40% less than the provincial average.

In 2004/05, there were 1,148 inpatient rehabilitation cases per 100,000 population for South East LHIN residents, a rate that is 40% below the provincial average of 1,928. The rate is not age standardized, so that given the older population in the South East, the age standardized rate of inpatient rehabilitation utilization would be even further below the provincial average. The lower rate of utilization of inpatient rehabilitation is likely a contributing factor to the high acute care ALC day rate for South East LHIN area residents.

In 2004/05, there were 874 South East LHIN area resident cases of discharges from an inpatient rehabilitation bed. 752 (86%) of these patients were inpatients in a South East LHIN hospital, 47 (5%) in a Toronto Central LHIN hospital, and 37 (4%) in a Champlain LHIN hospital.

There are only 78 inpatient rehabilitation beds in the South East LHIN, 27 of which are located in acute care hospitals and 51 in the two Providence Continuing Care Centre complex

[49] On September 29, 2006, the MOHLTC announced that the government is seeking applications to develop 352 new long-term care beds in the SE LHIN area. These beds are targeted to be available in 2009, and are not included in the analyses of beds per population.

continuing care sites (St. Mary's of the Lake Hospital in Kingston, and St. Vincent de Paul Hospital in Brockville). There were 793 discharges from South East LHIN inpatient rehabilitation beds, 752 of whom (95%) were South East LHIN area residents.

The exhibit following shows the distribution of the South East LHIN area inpatient rehabilitation patients by National Rehabilitation System (NRS) group, with a comparison of the overall distribution of rehabilitation patients by group across all Ontario rehabilitation providers, and with the Ottawa (Champlain) rehabilitation providers.

Exhibit 3.26: Distribution of 2004/05 South East LHIN Area Resident, Ontario, and Champlain Resident Inpatient Rehabilitation Patients by Rehabilitation Group

Rehabilitation Group	South East LHIN		All Ontario (excl. SE LHIN)		Champlain (Ottawa) LHIN	
	Cases	% of Total	Cases	% of Total	Cases	% of Total
Orthopaedic	341	39.0%	15,987	55.1%	1,049	44.5%
Stroke	216	24.7%	4,916	17.0%	481	20.4%
Medically Complex	25	2.9%	2,082	7.2%	177	7.5%
Debility	144	16.5%	952	3.3%	169	7.2%
Amputation	20	2.3%	960	3.3%	68	2.9%
Cardiac	8	0.9%	878	3.0%	55	2.3%
Pulmonary	28	3.2%	854	2.9%	130	5.5%
Spinal Cord	47	5.4%	652	2.2%	71	3.0%
Neurological	18	2.1%	645	2.2%	87	3.7%
Multiple Trauma	5	0.6%	331	1.1%	32	1.4%
Pain Syndromes	5	0.6%	318	1.1%	22	0.9%
Arthritis	13	1.5%	238	0.8%	7	0.3%
Other Impairments	2	0.2%	151	0.5%	8	0.3%
Burns	1	0.1%	18	0.1%	1	0.0%
Congenital	1	0.1%	13	0.0%	1	0.0%
Developmental	0	0.0%	5	0.0%	1	0.0%
Grand Total	874	100.0%	29,000	100.0%	2,359	100.0%
Population Aged 65 and Older	76,139		1,504,347		146,486	
IP Rehab Cases per 100,000	1,148		1,928		1,610	

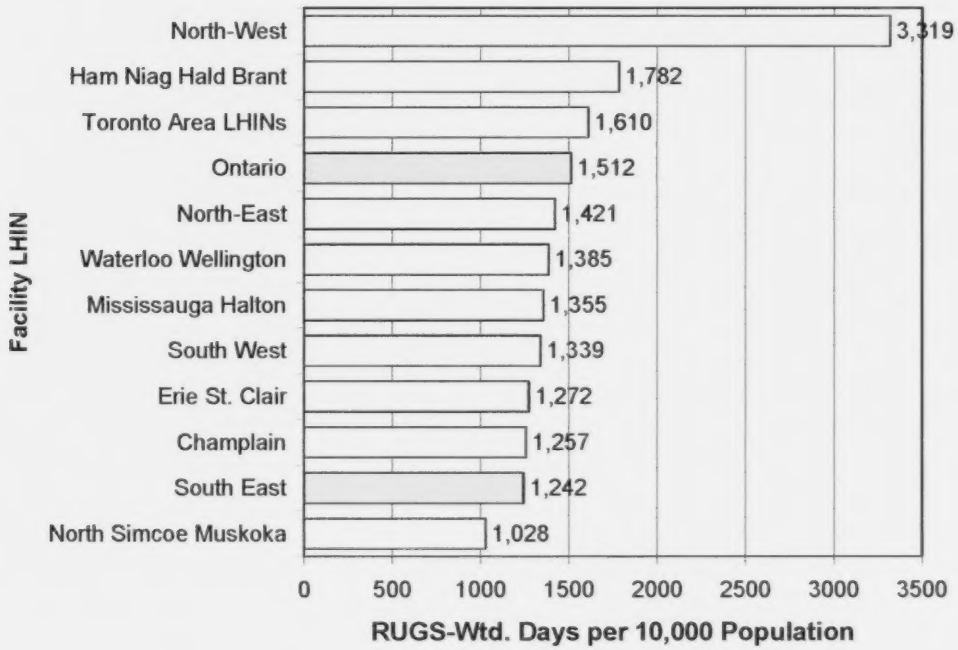
It is interesting to note that Rehabilitation beds in the SE LHIN area are being used more for Stroke, Medically Complex and 'Debility' patients (44.1%) than in the rest of the province (27.5%) and less for orthopaedic patients (39.0%) than in the rest of the province (55.1%).

3.4.7 *Utilization of Complex Continuing Care (CCC)*

There are 252 Complex Continuing Care beds in South East hospitals. Exhibit 3.27 shows the age-gender standardized

Complex Continuing Care RUGS-weighted[50] inpatient days per 10,000 age-gender standardized population by LHIN. The South East LHIN area rate is the second lowest in the province, suggesting there is less Complex Continuing Care bed capacity in the South East than in most of Ontario.

Exhibit 3.27: 2004/05 Age-Gender Standardized RUGS-Weighted Complex Continuing Care Days per 10,000 Population by LHIN



The average RUGS weight per case in South East hospitals is only slightly below the provincial average.

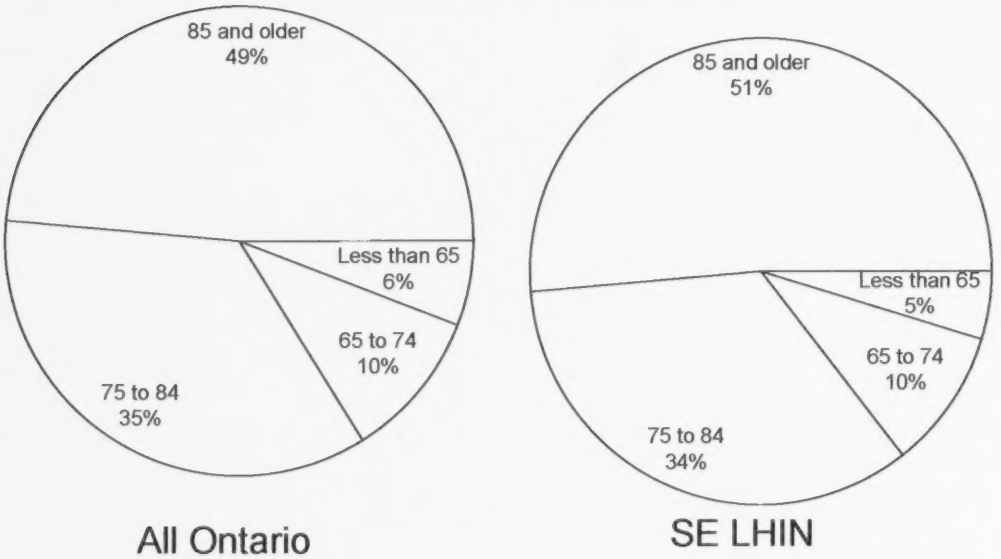
The low rate of utilization of complex continuing care in the South East should be examined further to determine the impact on high ALC day numbers in the South East acute care hospitals.

[50] Patients in complex continuing beds are classified into resource utilization groups (RUG) which are clinically relevant and resource-homogeneous groups based on information captured by the Resident Assessment Instrument Minimum Data Set (MDS 2.0). RUG-III is the current version of this classification system. A hospital's RUG-III weighted patient days adjusts for case mix differences in complex continuing care patients and allows comparison among hospitals.

3.4.8 Utilization of Long-Term Care Homes

While long-term care home beds are not used exclusively for elderly patients, these elderly patients represent the large majority of residents of long-term care (LTC) beds in Ontario. The exhibit following shows that in 2005, 84% of long-term care residents in Ontario were aged 75 years or older. In South East LHIN LTC facilities, 85% of residents were aged 75 years or older.

Exhibit 3.28: Distribution of Ontario and SE LHIN Area LTC Facility Residents in 2005 by Resident Age



Because of this, comparisons of LTC beds per capita usually use the elderly subset of the population as the denominator. The exhibit following shows the calculated number of LTC beds per LHIN population aged 75 years and older.

Exhibit 3.29: September 2005 LTC Beds per Elderly Population by LHIN

LHIN	Total LTC Beds	Pop'n 75 Plus	Beds per Pop'n 75 Plus
North East	4,663	38,221	122.0
Central West	3,313	28,296	117.1
North West	1,682	15,183	110.8
Champlain	7,388	69,801	105.8
Central East	9,456	90,822	104.1
South West	6,739	65,320	103.2
South East	**3,705**	**36,146**	**102.5**
Hamilton Niagara HB	10,267	100,479	102.2
Erie St. Clair	4,225	42,598	99.2
Waterloo Wellington	3,662	38,809	94.4
Mississauga Halton	4,250	45,104	94.2
North Simcoe Muskoka	2,530	27,072	93.5
Central	7,085	80,281	88.3
Toronto Central	6,132	74,807	82.0
Provincial Total	**75,097**	**752,939**	**99.7**

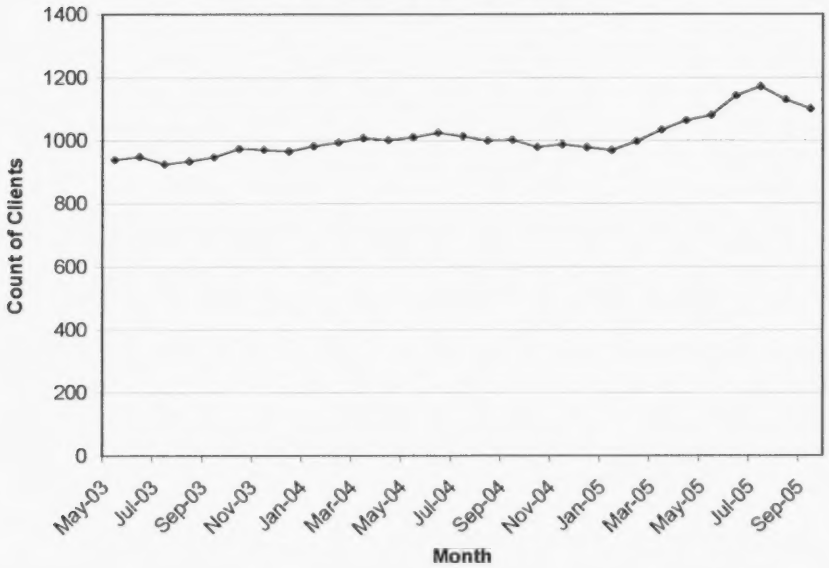
As can be seen, the number of beds in Long-Term Care Homes per population aged 75 years and older in the South East is 102.5, higher than the provincial average of 99.7.[51]

The SE LHIN area has the third highest ratio of community wait list to available beds of all of the LHINs in Ontario.

The number of people in the community waiting for admission to a LTC bed in the South East is increasing. The exhibit following shows the trend in the number of people waiting in the community for admission to a South East LHIN LTC bed. The number of people waiting for admission has increased from approximately 900 to 1,100 in the two and a half years shown.

[51] In September the MOHLTC announced that they were seeking applications to develop 352 new long-term care beds in the SE LHIN area. The beds will be available by 2009.

Exhibit 3.30: Community Resident LTC Facility Wait List Trend for SE LHIN Area



Expressed as a percentage of the total number of LTC beds, the September 2005 community wait list is equal to 29.5% of the total number of beds in the South East LHIN. The exhibit following shows that this is the third highest ratio of community wait list to available beds of all of the LHINs in Ontario.

Exhibit 3.31: Community Resident LTC Facility Wait List Trend and Ratio to Total LTC Beds by LHIN

LHIN	Sept 2005 Community Wait List	Total Beds	Wait List as % of Total Beds
Erie St. Clair	636	4,225	15.1%
South West	1,294	6,739	19.2%
Waterloo Wellington	705	3,662	19.3%
Hamilton Niagara HB	1,393	10,267	13.6%
Central West	122	3,313	3.7%
Mississauga Halton	357	4,250	8.4%
Toronto Central	1,202	6,132	19.6%
Central	970	7,085	13.7%
Central East	1,591	9,456	16.8%
South East	**1,100**	**3,705**	**29.7%**
Champlain	1,459	7,388	19.7%
North Simcoe Muskoka	907	2,530	35.8%
North East	836	4,663	17.9%
North West	513	1,682	30.5%
Ontario Total	**13,085**	**75,097**	**17.4%**

There is unmet need for LTC services in the South East LHIN area.

While the total number of LTC beds per elderly population in the South East LHIN area is higher than the provincial average, the large wait list, the very high percent occupancy of

LTC beds, and the high ALC day rate in acute care hospitals suggests that there is unmet need for LTC services in the South East LHIN. The lack of specialized long-term mental health facilities in the South East LHIN makes it difficult to accommodate LTC clients with difficult behavioural issues[52]

Residential care beds are only one component of the long-term care continuum.

However, residential care beds are only one component of the long-term care continuum. Retirement homes, supportive housing, and in-home services are all other ways that long-term care needs can be met. A recent study of community support services for seniors in Toronto[53] found that:

Supportive housing is a cost effective alternative to institutionalization, preferable in terms of quality of life and independence even for the oldest old.

"Our data suggest that supportive housing provides a viable, cost-effective option for integrating services, assessing outcomes, and ensuring accountability in the provision of care for the province's growing population of seniors. Judging by the relative risks of seniors in our study, supportive housing is a cost effective alternative to institutionalization, preferable in terms of quality of life and independence even for the oldest old. We especially stress the critical role of case managers in supportive housing in integrating services around the needs of clients, substituting lower cost services for more expensive institutional supports, and reducing demand on emergency services through ongoing assessments."

3.4.9 Home Care

Three CCACs primarily serving SE LHIN.

There are three CCACs that primarily serve the population of the South East LHIN:

- Hastings & Prince Edward (100% in South East)
- Kingston and FLA (100% in South East)
- Lanark, Leeds and Grenville (71.3% in South East)

And 5.9% of the population served by the Haliburton-Northumberland CCAC is located in the South East LHIN.

Data are not available to support comparison of home care utilization between the South East LHIN and other parts of the province.

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[52] The Ministry of Health and Long-Term Care, Long-Term Care Homes Branch, is currently conducting a survey to better understand how LTC homes care for residents with serious mental health or serious behavioural issues and looking at resources available in LTC homes and services available in the community.

[53] Janet M. Lum, Simonne Ruff and A. Paul Williams, "When Home is Community - Community Support Services and the Well-Being of Seniors in Supportive and Social Housing", A Research Initiative of Ryerson University, Neighbourhood Link/Senior Link and the University of Toronto Funded by United Way of Greater Toronto, April 2005.

3.4.10 Community Services

There is a wide range of providers of health services located across the South East LHIN. A listing of these providers is presented within an appendix to this IHSP.

In 2005/06, hospitals, long-term care homes and CCACs together had base funding equal to 92% of the total MOHLTC base funding for all LHIN related health care providers.

The exhibit following shows the total MOHLTC base funding by sector or program area for providers in the SE LHIN for those programs for which the LHIN is responsible from 2002/03 to 2005/06. The funding levels shown include only base operating funding. For many agencies there may be substantial MOHLTC funds provided each year on a one-time basis for a specific target or project. Also, the MOHLTC funds are not necessarily the sole source of all of the program expenditures. For example: most community service agencies are required to fund-raise a portion of their total budget each year, with the amount based on the amount of their MOHLTC base funding, and for most hospitals, MOHLTC funding represents only approximately 80% of their total operating revenues with additional revenues being provided by ancillary services such as parking, preferred accommodation and services to uninsured patients (RCMP, Canadian Armed Forces; Federal inmates; Out-of-Province; Out-of-Country and WSIB).

Exhibit 3.32: South East LHIN Provider Agency MOHLTC Base[54] Funding by Sector by Fiscal Year

Program	Fiscal Year				% Change (02/03 to 05/06)	% of 05/06 Total
	02/03	03/04	04/05	05/06		
Hospitals	$412,664,739	$454,149,918	$472,725,700	$521,219,000	26.3%	66.8%
LTC Homes	$92,819,251	$104,365,595	$113,254,456	$121,752,970	31.2%	15.6%
CCAC	$65,222,422	$65,904,322	$70,155,357	$76,846,255	17.8%	9.9%
Mental Health Programs	$20,831,656	$21,072,785	$23,873,883	$25,783,088	23.8%	3.3%
Comm. Suppt. Serv.	$10,959,283	$11,087,618	$11,965,351	$13,321,485	21.6%	1.7%
Comm. Hlth. Cntr.	$5,497,959	$6,860,099	$8,136,144	$9,585,954	74.4%	1.2%
Addictions	$4,284,370	$4,440,087	$4,867,156	$4,954,164	15.6%	0.6%
Acquired Brain Injury	$2,752,042	$2,752,042	$2,973,748	$3,181,541	15.6%	0.4%
Assist. Living Suppt. Housing	$1,804,534	$1,816,544	$1,895,793	$1,937,429	7.4%	0.2%
MH (Supportive Housing)	$1,073,928	$1,186,679	$1,248,217	$1,299,119	21.0%	0.2%
Grand Total	$617,910,184	$673,635,689	$711,095,805	$779,881,005	26.2%	100.0%

In 2005/06, hospitals, long-term care homes and CCACs together had base funding equal to 92% of the total MOHLTC base funding for all LHIN related health care providers.

The Exhibit following compares the 2005/06 base funding per capita by sector for all 14 LHINs.

[54] Excludes amounts for one-time funding and capital funding.

Exhibit 3.33: 2005/06 MOHLTC Per Capita[55] Base Funding[56] by Sector by LHIN where Provider is Located

LHIN	Funding per Capita (Total Population)										
	CCAC	Hospitals	LTC Homes	MH (Supportive Housing)	Assist. Living Suppt.	Comm. Suppt. Serv.	Acquired Brain Injury	Comm. Hlth. Cntr.	Addictions	Mental Health Programs	Grand Total
Toronto Central	$87	$2,593	$185	$15	$32	$60	$2	$48	$14	$72	$3,107
Ham. Niag. Hald. Brant	$144	$1,037	$247	$2	$15	$20	$9	$6	$8	$26	$1,512
Champlain	$116	$1,052	$203	$1	$5	$18	$1	$26	$10	$37	$1,469
South West	$129	$1,276	$234	$2	$12	$19	$6	$7	$6	$42	$1,732
Central East	$109	$599	$214	$2	$6	$16	$1	$5	$4	$20	$975
Central	$88	$519	$153	$1	$10	$14	$6	$2	$2	$25	$821
North East	$133	$1,131	$257	$4	$12	$31	$2	$12	$29	$68	$1,681
Mississauga Halton	$53	$568	$134	$0	$12	$15	$6	$0	$4	$11	$804
Erie-St. Clair	$124	$792	$212	$1	$7	$18	$1	$19	$8	$34	$1,217
South East	**$163**	**$1,105**	**$258**	**$3**	**$4**	**$28**	**$7**	**$20**	**$10**	**$55**	**$1,653**
Waterloo Wellington	$110	$669	$172	$1	$7	$15	$1	$16	$7	$29	$1,026
Central West	$117	$406	$161	$0	$5	$4	$0	$3	$2	$22	$721
North Simcoe Muskoka	$132	$685	$203	$2	$10	$18	$1	$7	$8	$35	$1,100
North West	$125	$1,360	$204	$7	$16	$35	$5	$22	$37	$96	$1,909
Ontario Average	**$111**	**$971**	**$198**	**$3**	**$11**	**$21**	**$4**	**$13**	**$8**	**$35**	**$1,375**
SE LHIN Rank	1	5	1	4	14	4	2	4	4	4	5

Because most health care services are disproportionately required by the elderly population, an alternative way of examining per capita costs is to look at the total base funding divided by the LHIN population aged 65 years and older. The exhibit following shows a comparison of total base funding per population aged 65 and older. The funding numbers are not limited to funding for services provided exclusively to the elderly population, so the resulting calculations should be interpreted with caution.

[55] Not adjusted for differences in age or gender composition of the populations in the LHINs

[56] Excludes amounts for one-time funding and capital funding.

Exhibit 3.34: 2005/06 MOHLTC Base Funding[57] per Population Aged 65 Years and Older by Sector by LHIN Where Provider is Located

LHIN	Funding per Capita (Residents 65 Years Old and Older)										
	CCAC	Hospitals	LTC Homes	MH (Supportive Housing)	Assist. Living Suppt.	Comm. Suppt. Serv.	Acquired Brain Injury	Comm. Hlth. Cntr.	Addictions	Mental Health Programs	Grand Total
Toronto Central	$698	$20,843	$1,483	$118	$260	$484	$17	$383	$115	$576	$24,978
Ham. Niag. Hald. Brant	$955	$6,880	$1,638	$12	$100	$130	$57	$37	$50	$174	$10,032
Champlain	$934	$8,443	$1,629	$8	$44	$146	$9	$209	$77	$299	$11,798
South West	$888	$8,770	$1,607	$13	$80	$132	$42	$45	$40	$286	$11,904
Central East	$831	$4,575	$1,632	$12	$49	$120	$6	$37	$34	$152	$7,448
Central	$755	$4,432	$1,306	$11	$81	$122	$47	$15	$19	$216	$7,006
North East	$854	$7,237	$1,646	$24	$78	$201	$15	$74	$187	$438	$10,755
Mississauga Halton	$540	$5,823	$1,374	$2	$124	$155	$61	$0	$42	$116	$8,240
Erie-St. Clair	$906	$5,805	$1,556	$7	$55	$129	$11	$140	$61	$250	$8,920
South East	**$1,007**	**$6,833**	**$1,596**	**$17**	**$25**	**$175**	**$42**	**$126**	**$65**	**$338**	**$10,224**
Waterloo Wellington	$943	$5,732	$1,471	$6	$62	$125	$11	$136	$59	$246	$8,791
Central West	$1,227	$4,266	$1,689	$2	$53	$46	$0	$29	$19	$234	$7,566
North Simcoe Muskoka	$909	$4,706	$1,393	$11	$69	$125	$7	$46	$52	$241	$7,559
North West	$939	$10,239	$1,536	$56	$124	$265	$38	$163	$281	$725	$14,366
Ontario Average	**$863**	**$7,553**	**$1,541**	**$21**	**$89**	**$167**	**$28**	**$98**	**$64**	**$275**	**$10,699**
SE LHIN Rank	2	7	7	4	14	4	5	6	5	4	6

The per capita calculations are based on the funding provided to providers located within the LHINs and the resident population of the LHINs. Because some providers located in one LHIN provide substantial amounts of service for non-residents of the LHIN, and because some residents of one LHIN rely greatly on providers located in other LHINs, the per capita calculations do not necessarily accurately reflect the cost of the care LHIN residents actually receive.

Particularly for hospital care, some non-residents of the South East LHIN area will travel to a South East LHIN area facility for care. While the cost of providing their care is included in the South East LHIN hospital costs, they won't be included in the population number used to calculate the per capita funding for the South East. Data relating service utilization to individuals is most readily available for hospital patients. The exhibit following shows an estimate of the average acute care (inpatient and ambulatory procedure) expenditures per LHIN resident for fiscal year 2004/05 based on the residence of the patient; not the location of the provider[58].

[57] Excludes amounts for one-time funding and capital funding.

[58] Both the acute care inpatient and ambulatory procedure data (day surgery and medical day/night care) have cost weights assigned to each case. The inpatient cases have "Resource Intensity Weight" (RIW) values and the ambulatory procedure cases have "Comprehensive Ambulatory Category" (CACS) weights. These cost weights describe the relative cost to provide care to the patients and can be used, when combined with hospital-specific operating cost data, to estimate the cost of the care for each case. The cost weights for each inpatient and ambulatory procedure case were combined with the actual 2004/05 cost per

Exhibit 3.35: Age/Gender Standardized Acute Care Expenditure per LHIN Resident in 2004/05[59]

Patient LHIN	Inpatient	Ambul.	Total Cost	% of Ontario Avg.
Mississauga Halton	$343	$87	$429	83%
Central	$353	$97	$450	87%
Waterloo-Wellington	$357	$104	$461	89%
Central West	$370	$97	$467	90%
Central East	$376	$105	$481	93%
North Simcoe Muskoka	$383	$112	$496	96%
Champlain	$422	$91	$514	99%
Ontario	**$415**	**$104**	**$519**	**100%**
Toronto Central	$431	$90	$520	100%
Ham Niag Hald Brant	$434	$96	$530	102%
Erie St. Clair	$419	$113	$532	103%
South West	$479	$106	$585	113%
South East	**$483**	**$120**	**$603**	**116%**
North East	$509	$133	$642	124%
North West	$552	$129	$681	131%

The cost of the average annual acute care utilization per population for residents of the South East LHIN was $603, the highest expenditure per population of LHINs in southern Ontario.

In 2004/05, the average annual cost of acute care services used by residents of the South East LHIN was $603, the third highest rate of expenditure of all LHINs, and the highest expenditure per population of the 12 LHINs in southern Ontario. The acute care hospital expenditure data includes the higher costs incurred by academic health science centres to support their academic mission, and contribute to the higher than average expenditures for the residents of many of the LHINs that contain academic health science centres (e.g. Champlain (Ottawa), South East (Kingston), South West [London], Hamilton Niagara Haldimand Brant [Hamilton], and Toronto Central [Toronto]).

3.5 Health Human Resources

There is recognition within the health care system that the availability of sufficient and qualified health care workers across numerous disciplines and occupation groups is one of the leading issues. Until recent efforts, no appropriate systems

weighted case for each Ontario hospital to assign a case cost to each record. This cost data set was then used to calculate the age/gender standardized acute care operating cost per population for each of the 14 LHINs. Records were assigned to each LHIN on the basis of the patient residence. Operating costs were assigned to each case on the basis of the operating costs of the hospital where the care was provided.

[59] CIHI Discharge Abstract Database (DAD), National Ambulatory Care Reporting System (NACRS), Ontario Ministry of Finance Spring 2006 draft, unpublished population estimates, and Ontario JPPC Rates Formula cost per weighted case data.

or structures existed to support human resource planning and development at either the national, provincial or local level.

MOHLTC goal for HHR is that "Ontario will have the right number and mix of appropriately prepared health care providers when and where they are needed."

The Ontario Ministry of Health and Long Term Care's health care system transformation effort has stated its goal for Health Human Resources (HHR) as follows:

"Ontario will have the right number and mix of appropriately prepared health care providers when and where they are needed."[60]

Ontario's LHINs will need to assure that they have the right people at the right place, at the right time, and with the appropriate tools and equipment, to meet the needs of their population. They will also need to have people with the right mix of knowledge and skills who are able to work together in new ways to provide more patient centred, needs-based care.

Although initial Health Human Resources information available to the South East LHIN pertains mainly to physicians and nurses, there are a variety of health care providers, both regulated and unregulated, that must be considered if an integrated, systems approach to Health Human Resources planning is to be achieved.

A number of challenges have been identified for HHR planning and development.

A number of challenges have been identified for Health Human Resources planning and development in Ontario including:

- A change in the supply of practitioners relative to the needs of the population
- Changes in the practice of medicine and in the way in which patients seek medical care and therefore the need for HHR
- An uneven distribution of the workforce among professions and skills which has resulted in a shortage of certain types of workers (such as family practitioners and medical laboratory technologists) and skills (such as operating room nurses)
- An uneven geographic distribution of practitioners, with a tendency to cluster in urban and high density areas, that is inconsistent with population needs
- Changes in the characteristics of the workforce with respect to age, gender and life-style objectives that has

[60] The Health Quality Council of Ontario. *Laying the Foundation for Change. A progress report on Ontario's Health Human Resources Initiatives.* December, 2005.

resulted in decreases in the quantity of service hours available even when numbers of available workers has stayed the same

- Poor synchronization of training with needs for workers
- Lack of understanding of the relationship between population health and the need for health care workers
- Segmented HHR planning, development and recruitment by individual disciplines, employers or sub-sector groups, rather than by a region or the system as a whole
- Quality of work-life issues that have led to difficulty retaining skilled staff in the health care sector
- Shortages of workers which has created a competitive environment for recruitment and retention within the health care sector and between health care and other industries

Multiple initiatives to address issues of Health Human Resources have been put in place in Ontario.

In order to obtain the goal of "the right number and mix of appropriate health care providers when and where they are needed", multiple initiatives have been put in place in Ontario, including:

- Establishing a new Assistant Deputy Minister of HHR in the Ministry of Health, as a commitment to this priority
- Alignment of the Ministries of Health and Education, with additional funding supplied to increase capacity in medical schools, nursing and other allied health programs
- Use of new health data management strategies, including the development of databases and forecasting techniques for nine types of care providers
- Increasing the number of spots for post secondary and graduate training in family medicine, nursing, nurse practitioners, midwifery, pharmacy, medical laboratory, imaging and physics
- Funding for bridging programs to expedite the ability of internationally trained midwives, physicians and nurses to practice in Ontario
- Establishing mechanisms, including Clinical Centres of Excellence, to ensure that nursing jobs are more attractive
- Establishing mechanisms to ensure that providers have the opportunity to train and practice in rural and remote areas, and with under serviced populations
- Promoting team based practice, by funding interdisciplinary education, new practice roles and new

family health teams and community health centres throughout Ontario

- Funding the use of technology, such as clinical simulators and telemedicine, to improve the quality of care and promote access and skills development in under serviced communities
- Providing funding for a variety of approaches to improve the quality of worklife for nurses

Although these are Ontario-wide initiatives, the South East has been able to participate in, and should continue to capitalize on, the work in this area.

Planning must include development of provincial, local and sector specific strategies for addressing short, intermediate and long term HHR challenges.

It is anticipated that the current challenge of providing adequate numbers and types of health care professionals will continue to grow as our population increases and ages in the next decade. All LHINs, including the SE LHIN, are under intense pressure to provide accessible, effective and efficient services in response to the needs of the population. Planning must include development of provincial, local and sector specific strategies for addressing short, intermediate and long term HHR challenges.

3.6 Health Care Education and Research

3.6.1 Support for Academic Health Science Centres

Support for health care education and research will be critical to the ability of the providers in the South East LHIN to respond to the needs of the population for health care services.

Support for health care education and research in the South East LHIN, and in other LHINs such as Champlain, Central East, North East and the Toronto area will be critical to the ability of the health care providers in the South East LHIN to respond to increasing population needs. Support for education and research will be particularly important to the South Eastern Ontario Academic Health Sciences Centre, where the most complex patients are treated, where much of the education and training of future health professionals is focused, and where new technologies and best practices are identified and diffused. The integrated South Eastern Ontario Health Sciences Centre (SEOHSC) includes Kingston General Hospital, Hotel Dieu Hospital, Providence Continuing Care Centre, the Kingston Regional Cancer Centre, and Queen's University. The SEOHSC is a resource not just to the South East LHIN, but to the entire province and beyond. Similarily, the entire province, and beyond, is a resource to SEOHSC.

3.6.2 Queen's University

The Queen's University, Kingston, Faculty of Health Sciences is the largest provider of health care related education and

research in the South East LHIN and is responsible for undergraduate and postgraduate medical programs and for the programs of the School of Rehabilitation Therapy and the School of Nursing. Other health care education departments and programs offered at Queen's University include:

- Biomedical Computing
- Community Health and Epidemiology
- Life Sciences (including departments of Anatomy & Cell Biology, Biochemistry, Microbiology & Immunology, Pathology, Pharmacology & Toxicology and Physiology)
- Centre for Neuroscience Studies
- Pathology and Molecular Medicine
- Pharmacology and Toxicology
- Psychology
- Eastern Ontario School Of X-Ray Technology Information (with KGH)

Educational placements essential for the training of medical residents in 16 specialty SEOHSC programs include not only hospitals and medical practices in the South East LHIN area, but also span across the Central East, Champlain, North East, Toronto area LHINs.

3.6.3 Other Health Education Institutions

Other health education institutions in the South East LHIN include:

- Loyalist College (Belleville) - Fitness and Health Promotion, Nursing – Degree, Paramedic Program (Bancroft Campus), Personal Support Worker, Practical Nursing, pre-Health Sciences, and Social Service Worker
- St. Lawrence College (Kingston) - Pre-Health Sciences (Pre-BScN), Bachelor of Science in Nursing (BScN), Fitness & Health Promotion, Health Information Management, Medical Laboratory Science, Medical Laboratory Technician, Paramedic, Personal Support Worker, and Practical Nurse

It is important to note that health care education organizations located outside the South East LHIN also support the South East LHIN and use South East LHIN hospitals for clinical placements.

3.6.4 Clinical Research

Research in the South Eastern Ontario Academic Health Center is carried out mainly in the Faculty of Health Sciences (FHS) and its three affiliated teaching hospitals, the Kingston General Hospital (KGH), the Hotel Dieu Hospital (HDH) and Providence Continuing Care Hospital (PCC). Other Faculties at Queens, such as the Faculty of Applied Science, and the Faculty of Arts and Sciences, also contribute to the academic health research enterprise, and other clinical centres, such as Ongwanada Hospital and the Kingston Public Health Unit house Queen's Faculty engaging in Research. Most clinical researchers have faculty appointments at Queens, greatly simplifying research coordination in a small centre. SEOHSC researchers work in collaboration with researchers in other academic health science centres in Ontario, across Canada, and internationally.

3.7 E-Health Readiness

South East LHIN hospitals significantly exceed the provincial average capability with respect to "information sharing with other hospitals".

In 2005, the Ontario Hospital Association assessed the preparedness of Ontario hospitals to engage in the provincial e-Health strategy using the Ontario Hospitals Connected for Care: 2005 EHR Readiness Survey to measure organizations capability and use of Electronic Health Record (EHR) solutions. A report describing the e-Health readiness of South East LHIN hospitals was published in August 2005. The areas covered in the survey were:

1. Level of Electronic Patient Record (EPR) functional capability and use
2. Level of Electronic Patient Record (EPR) organizational and human capacity
3. Level of regional/inter-organizational Electronic Health Record (EHR) readiness

For most indicators, the South East LHIN result was very similar to the overall provincial average result. The one area where South East LHIN hospitals were found to significantly exceed the provincial average capability was "Provincial information sharing with other hospitals".

The indicators where the South East LHIN result was below the provincial average were:

- Order entry use
- Inter-Organizational Electronic Master Patient Index Capability

- Inter-Organizational Electronic Master Patient Index Use
- Interoperability Use with EHR or other EPR

These scores suggest that hospitals in the South East LHIN are relatively less prepared for sharing patient information with other providers.

The Health Care Network (HCN) of Southeastern Ontario Information Technology & Telecommunications Steering Committee (ITTSC) was established to lead the implementation of integrated and regional information technology and communications projects of the member organizations.

In August 2004, the Health Care Network of Southeastern Ontario[61] (HCN) Information Technology & Telecommunications Steering Committee (ITTSC) was established as the guiding body providing leadership for the prioritization and implementation of the integrated and regional information technology and communications projects of the member organizations. The ITTSC has developed a regional strategic information plan to support a local health integration network model for HCN members and continually improve regional information technology and communication services delivery.

The plan creates a unified vision for future information technology and communications in Southeastern Ontario which is consistent with national and provincial directions. The plan focuses on 5 strategic themes:

1. Regional Connectivity
2. Electronic Health Records
3. Telemedicine
4. Shared Infrastructure
5. Community Physician Access

The plan introduces and emphasizes the importance of a regional approach to strategic information technology and communications planning. The proposed approach focuses on the integration of information among existing legacy systems, as opposed to a forced migration to a common system.

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[61] Members of HCN are the Access Centre for Community Care in Lanark, Leeds & Grenville, Brockville General Hospital, Hastings/Prince Edward Community Care Access Centre, Hastings/Prince Edward Health Unit, Hotel Dieu Hospital, Kingston, Frontenac, Lennox & Addington Community Care Access Centre, Kingston, Frontenac and Lennox & Addington Public Health, Kingston General Hospital, Kingston Regional Cancer Centre, Cancer Care Ontario Regional, Leeds, Grenville & Lanark District Health Unit, Lennox & Addington County General Hospital, Perth and Smiths Falls District Hospital, Providence Continuing Care Centre, Queen's University Faculty of Health Sciences, Quinte Healthcare Corporation.

It is expected that this plan will be the starting point for the development of a SE LHIN e-Health Plan. The focus of the LHIN plan will be on inclusivity (all sectors) in breadth and depth as well as the development of a detailed action plan for achieving connectivity among sectors and providers across sectors. The providers' Regional IT plan is to focus on integration of information, while maintaining existing legacy systems as opposed to a forced migration to a common system. It is expected that further investments will be in concert with the move to an integrated, shared system. Opportunities for achieving further integration of information and economies of scale through integration of both hardware and software systems will be pursued with all future purchases.

4.0 LHIN Priorities for Change

For the most part the health system in the SE LHIN is working well.

The analysis of the health status of the population, the utilization of health services, the capacity and capability of health service providers in the LHIN and most importantly the community engagement and stakeholder consultation processes undertaken as part of the development of this Integrated Health Services Plan for the South East LHIN have convinced us that for the most part the health system is working well, especially in comparison to other parts of the province, the country and especially the rest of the world.

However, together, the Community Engagement and Environmental Scanning activities undertaken during the development of this Integrated Health Services Plan identified population health and health system development needs in the SE area. All of these needs are felt to be important and addressing these needs can improve the functioning of our local health care system and the health of our population. However, not everything can or should be done at once. The SE LHIN has selected several of these needs for further investigation and development of LHIN activities over the three years that this Plan addresses. These areas are called Priorities for Change. Priorities have been selected based on indications of urgency, community readiness for development, legislative and regulatory requirements, resource availability etc. It is important to note that these are all priorities for the LHIN; the order of presentation is not intended to suggest any relative importance among them. These priorities are:

- Improving access to:
  - Primary Health Care
  - Specialized Medical Care
  - Mental Health Services
  - Addiction Services
  - Rehabilitation Services
  - Transportation to and from Health Care
- Improving the availability of long-term care services
- Making the movement of patients between different health care organizations and professionals easier
- Developing better communication between the South East LHIN and local aboriginal communities
- Improving access to health care services in French

- Moving ahead with the development and use of electronic health information systems
- Developing a regional health human resources plan

Each of these is discussed briefly in the paragraphs following.

4.1 Access to Care

Residents of the LHIN report some difficulties in accessing needed health services.

Access to care is a major issue within the South East LHIN. Different communities, different special needs populations and different geographies have different issues, but residents of the LHIN report that they experience some difficulties in accessing needed health services. The issues related to the priority areas for improving access are discussed briefly in the paragraphs following.

4.1.1 Access to Primary Health Care

Access to family physicians was identified as a priority issue in all parts of the LHIN, except Prince Edward County.

Primary health care can be defined as a set of first level services that promote health, prevent disease, and provide diagnostic, maintenance, curative, rehabilitative, supportive and palliative services.[62]

Primary health care serves a dual function in the health care system:

- Direct provision of first-contact services (by providers such as family physicians, nurse practitioners, nurse managed telephone advice lines, etc)
- Coordination of services to ensure continuity and ease of movement across the system, so that care remains integrated when Canadians require more specialized services (with specialists or in hospital, for example)[63]

It is generally agreed that the scope of services offered by primary health care should include:[64,65]

- Health promotion[66]

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[62] Lamarche, P., Beaulieu, M., Pineault, R., Contandriopoulos, A., Denis, J. & Haggerty, J. *Choices for Change: The Path for Restructuring Primary Healthcare Services in Canada.* Canadian Health Services Research Foundation. (November, 2005).

[63] Health Canada Website: About Primary Health Care at www.hc-sc.gc.ca/hcs-sss/prim/about-apropos/index_e.html

[64] Ibid.

[65] Fooks, C., *Implementing Primary Care Reform in Canada: Barriers and Facilitators.* Canadian Policy Research Networks, Inc. (January, 2004).

- Disease prevention
- Treatment of common diseases and injuries
- Primary mental health care
- Chronic disease management
- Healthy child development
- Primary maternity care
- Basic emergency services
- Referrals to and coordination with other levels of care
- Rehabilitation Services
- Palliative and end of life care

Difficulty in gaining access to primary care physician services was overwhelmingly identified as a priority issue in all areas of the SE LHIN, except Prince Edward County. Challenges with access to family doctors appeared common to all rural and urban locations, all age groups and types of patients. An inadequate supply of family physicians was reported as the cause for these difficulties.

Many people identified that they simply are unable to get a family doctor. Some communities, such as Kingston and Trenton, reported that more than 15% of patients seen in local Emergency Departments are orphaned patients.[67] It was reported that new residents to an area are typically not able to secure a family doctor, and often travel back to their former communities to access their previous family physician. Long time residents can also become orphaned, typically because their family doctor has retired, died or moved away.

Many patients are on long waiting lists for family practices.

It was reported that many patients are on long waiting lists for family practices. Disturbingly, people in several communities reported being "turned down" or "released" by a family practice. They frequently noted that they thought this occurred because the nature or complexity of their problems resulted in them being viewed as "less attractive" patients for doctors with busy family practices.

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[66] Health promotion with the general population is primarily the responsibility of public health. Primary Health Care Providers should collaborate with Public Health to identify areas of focus and to deliver health promotion services.

[67] People with no regular family physician.

The availability of providers in the South East is inadequate to the needs of the population for primary health care.

The findings of the engagement and consultation processes are reinforced by our data analysis that show that use of a family physician and availability of family physicians in the South East LHIN are similar to the average for the province. There is strong evidence that the average use of family physicians for the province is inadequate to the needs of the population for primary health care.

Importantly there appears to be significant variation in physician supply within the LHIN such that some areas of the LHIN may have more or less access to family practice services than others.

There is a need for health education and chronic disease management services.

The relatively large number of people in the SE LHIN with chronic disease and the relatively high rate of hospitalization for ambulatory care sensitive conditions suggest a need for primary health care services, especially for health education and disease management services. The apparent shortage and lack of access to primary care physicians are likely impediments to effective health education and chronic disease management in the South East LHIN. In addressing this issue consideration should be given to integrated, multi-disciplinary models of primary health care that have been shown to be effective vehicles for delivering these services, especially for people with chronic diseases.

4.1.2 Access to Specialty Care

The difficulties in accessing specialist and subspecialist[68] physician care and supporting diagnostic services were identified as a concern in all communities, whether urban or rural. Supply issues, as well as issues of geographic access were identified as being barriers to access.

The shortage of family doctors is contributing to the challenge of accessing specialist care.

It was felt by participants in the community engagement and stakeholder consultation sessions that the shortage of family doctors is contributing to the challenge of accessing specialist care. It was suggested that since a referral from a family doctor is usually required to see a specialist, it would seem that difficulty in accessing family physicians is by itself creating difficulties in accessing specialist care. It was also suggested that, because family physician workloads are high, family physicians may be referring to specialists rather than pursuing investigations that would, with sufficient time, be well within their scope of practice. If true, the number of referrals to specialists likely is higher than is necessary.

[68] The issue of access to specialty physician services focuses mostly on subspecialist care.

Perhaps the queues and wait times to see specialists are increasing, at least partially, as a result of these behaviours. And specialists indicated that because there is a shortage of primary care physicians, they are forced to provide follow-up care themselves, rather than pass patients on to the patient's primary care provider.

There are significant barriers to accessing specialist care.

Barriers to accessing specialist physicians were routinely identified, no matter how near or distant the community from the urban centres where specialists practice. With very few exceptions, patients are required to travel to Kingston, Belleville, Trenton or Ottawa to access specialist care. The need to travel, particularly if multiple appointments are required, becomes a significant barrier to accessing needed specialist care.

Specialty groups most commonly indicated as being in short supply included dermatology, obstetrics and gynaecology, orthopaedics, paediatrics, plastic surgery, psychiatry, and rheumatology.

Once patients are able to access a specialist physician, access to hospital treatment is as good as elsewhere in the province.

However, it appears, from the data regarding rates of hospitalization for secondary and tertiary hospital care, that once patients are able to access a specialist physician, access to inpatient and outpatient hospital treatment is as good as elsewhere in the province.

4.1.3 Access to Mental Health Services

There are difficulties in accessing the entire continuum of mental health services.

There are reported difficulties in accessing the entire continuum of mental health services, from crisis care to chronic community support in all communities within the LHIN.

Crisis care services were identified as a particular challenge in many communities. Communities outside of the urban centres of Kingston and Belleville are relying on telephone access to psychiatrists and crisis teams in those cities to support crisis psychiatric care in the local ED; and although this support is available, they report that they are having difficulty in gaining access to inpatient psychiatric care when it is required.

People with long term or chronic mental health problems also identified issues with accessing services, especially ambulatory care and community support services. Access to services was reported as a problem in all communities across the South East LHIN from small rural communities to the urban centres of Kingston and Belleville. Providers felt strongly that access to adequate community services is required to decrease the "revolving door" of demand for crisis

and acute care services. Regional providers in Kingston identified a particular concern regarding the inadequacy of community support to replace the soon to be eliminated inpatient chronic psychiatric care beds.

Access issues were reported to be especially problematic with respect to psycho-geriatric services, child and adolescent psychiatry, people with concurrent disorders, homeless people with mental health problems and forensic psychiatry.

4.1.4 Access to Addiction Services

People have a significant problem in accessing addiction services throughout the region.

It is reported that people have a significant problem in accessing addiction services throughout the region. These patients often have to leave their home community to access treatment. Outside of the urban settings, there are no local withdrawal management or detox options available. It was reported that transportation is difficult to obtain or prohibitively expensive for patients who do seek services outside their local community. Also, patients have difficulty with medication management because they often lack family physicians for follow-up and treatment management. It is reported that supportive housing options to help these patients stay in the community are inadequate throughout the South East.

4.1.5 Access to Rehabilitation Services

Residents of the SE LHIN use inpatient rehabilitation at a rate far below the provincial average.

Residents of the SE LHIN use inpatient rehabilitation at a rate far below the provincial average. It is reported that there is a problem in accessing inpatient rehabilitation services. Only 1.6% of acute care hospital inpatient admissions in the SE LHIN are discharged to an inpatient rehabilitation bed; and these patients spend 18% of their time in acute care waiting for transfer to an inpatient rehabilitation program.

There are significant deficits in the availability of and access to community rehabilitation services.

This might not be a significant problem were there adequate access to community rehabilitation services. However, it is reported that there are significant deficits in the availability of and access to community rehabilitation services. Importantly, providers indicate that the demand for insured in-home rehabilitation services exceeds the supply, and patients must wait for care. Constraints on hospital budgets limit their ability to provide outpatient rehabilitation services. Hospital outpatient services are further limited, as are all rehabilitation service agencies, by difficulties in attracting therapists, especially in the smaller, more rural hospitals.

Even when patients are able to pay for privately funded services, it is reported that the shortage of therapists makes

timely access difficult; especially for rehabilitation services delivered in a person's residence.

4.1.6 Transportation To and From Care

Emergency transportation services are well provided across the region.

Stakeholder consultation revealed a consensus that emergency transportation (ambulance) services are well provided across the region. However, participants were quick to note that while it is relatively easy to get a patient to emergency or acute care hospital services, transporting them back from services after the emergency or acute care has been received can be a particular challenge.

Transportation to access non- emergency medical care is a concern in all SE LHIN communities.

Similarly, transportation to access non-emergency medical care was identified as a concern in all communities. Those without their own transportation must rely on other transport options, which are reportedly lacking in most communities or inaccessibly expensive. Only the large urban centres have public transportation options. Although private medical transportation services and taxis are available in most communities, and some level of transportation is usually available through community support services, these options are reportedly inadequate or too costly to meet current demand.

Moreover, it is reported that wheelchair or stretcher accessible transportation options are not available in many communities. People in need of these services must rely on the limited supply of private medical transportation services to provide transportation.

Without transportation, people will be unable to access even expanded and improved health services in the region. Planning by the LHIN needs to consider the population's need for transportation to and from health care services.

Also, transportation of patients between hospitals for needed specialized treatments and diagnostic services requires improvement; especially urgent, time dependent patient transportation.

4.2 Availability of Long Term Care Services

Almost 60% of patient days spent in hospital waiting for an alternate level of care are waiting for some form of residential long-term care.

People in the South East LHIN need to wait for residential long-term care services. 47% of ALC patient days in South Eastern Ontario hospitals are used by patients who are discharged to long-term care homes. A further 13% are used by patients discharged to Complex Continuing Care (Chronic Care Facility). Taken together, almost 60% of patient days

spent waiting for an alternate level of care are waiting for some form of residential long-term care.

People in the community are also waiting for admission to long term care homes. The community wait list ratio of people waiting to beds available in the SE LHIN is the third highest of all the LHINs in Ontario, and it has been increasing.

Residential care beds are only one component of the long-term care continuum. Retirement home beds, supportive housing places, and in-home services are all other ways that long-term care needs can be met. However, it is reported that these alternative modalities of long-term care services are also in short supply in all or many communities in the SE LHIN.

4.3 Integration of Services Along the Continuum of Care

Improvement in the integration of services and service provision along the continuum of care will be especially important for the large number of people in the SE LHIN with chronic diseases.

Participants in the community engagement process overwhelmingly supported the need to improve coordination along the continuum of care within the health care system in the SE LHIN. The *hand-offs* of patients between providers were identified as most problematic. Examples of the hand-offs that are particularly problematic are those from a primary health care provider to the hospital emergency department; from one hospital to another; from hospital back to a primary health care provider, and from hospital to a geographically remote home care provider. There appear to be opportunities to implement new processes and mechanisms to improve patient flow throughout the system. There was consensus that there is a need for more coordinated transitions within the system and these could be improved by focusing on standardization of processes, facilitation of information sharing and reduction of duplication.

Improvement in the integration of services and service provision along the continuum of care will be especially important for the large number of people in the SE LHIN with chronic diseases. Because of the nature of their diseases, many of these people have ongoing rather than episodic interaction with multiple rather than individual elements of the health system. Integration of services along the continuum will improve the quality of their care and minimize the disruptions in the quality of life and health that are often caused by discontinuities in the health system.

4.4 Engagement with Aboriginal Communities

First Nation populations have reduced life expectancy and poor health status compared to the general Canadian population.

Canadian studies of First Nation's health care have consistently shown that First Nation populations have reduced life expectancy and poor health status compared to the general Canadian population. The LHIN will need to develop and implement a framework for ongoing dialogue with on-reserve and off-reserve First Nation and off-reserve communities within the LHIN. The provincial Aboriginal Wellness Strategy likely will provide a framework to involve this population in the engagement process.

It will also be important to establish a dialogue with the NE LHIN regarding services that are provided to their aboriginal populations by the medical community in Kingston, specifically with respect to dialysis services provided to residents of Moose Factory.

4.5 Ensuring French Language Services

Lack of access to French language services may be affecting the quality of health services and the health of francophone residents of the South East LHIN.

It is reported that there is a lack of health professionals (e.g. family doctors, surgeons, specialists and nurses) who can provide services in French. There is also a lack of focus on ensuring the availability of French language services. These are believed to be significant barriers to accessing health services for the francophone population in the region. Implications of the language barrier include:

- Reduced probability of using health services for preventive reasons
- Increased consultation time and use of diagnostic tests, and increased probability of error in diagnosis and treatment
- Impact on the quality of care, reduced probability of compliance with treatment, and reduced satisfaction with care and services

The lack of access to French language services in the South East LHIN may affect the quality of health services and the health of francophone residents.

4.6 Integration of E-Health

Sharing information along the continuum of care is especially important in addressing the needs of the large number of people with chronic diseases in the SE LHIN.

The Ontario Hospital Association 2005 EHR Readiness Survey found that hospitals in the South East LHIN were below the provincial average with respect to:

- Inter-Organizational Electronic Master Patient Index Capability
- Inter-Organizational Electronic Master Patient Index Use

- Interoperability Use with Electronic Health Record (EHR) or other Electronic Patient Record (EPR)

These scores suggest that hospitals in the South East LHIN are relatively less prepared for sharing patient information with other providers than hospitals in other parts of the province. This finding was confirmed in our stakeholder consultation sessions. Other agencies are apparently no better prepared for electronic sharing of patient information.

Although there has been much progress, most participants indicated the continuing need for an electronic patient record to make current patient information available to all providers. Without such a tool, there will be duplication, inefficiencies and potentially errors. It was suggested that sharing information is especially important in addressing the needs of the large number of people with chronic diseases along the continuum of care.

4.7 Regional Health Human Resources Plan

The LHIN should take a leadership role in developing an overall health human resources plan for the region.

There is recognition within the health care system that the availability of sufficient and qualified health care workers across numerous disciplines and occupation groups is one of the leading issues. Until recent efforts, no appropriate systems or structures existed to support human resource planning and development at either the national, provincial or local level.

Many participants in the stakeholder consultation sessions felt that the LHIN should take a leadership role in developing an overall health human resources plan for the region. Some suggested that the LHIN should also lead in the implementation of the plan by all health service agencies including recruiting, retaining and developing all the health services providers that are and will be needed in the LHIN. It was suggested that a regional process would keep providers within the region from 'poaching' staff from one another.

The plan should build upon the prior work in Hastings and Prince Edwards Counties in developing a preliminary human resources planning framework, "Directions: Moving Forward with Health Human Resources."

5.0 LHIN Priorities and MOHLTC Strategic Directions

The exhibit on the following page shows the relationship of the priorities for change of the South East LHIN with the draft strategic directions articulated by the Ministry of Health and Long-Term Care. As can be seen each SE LHIN priority for action addresses one or more of the MOHLTC strategic directions.

MOHLTC Draft Strategic Directions	SE LHIN Priorities for Change						
	1	2	3	4	5	6	7
	Access To Care	Availability Of Long Term Care Services	Integration Of Services Along Continuum	Engagement With Aboriginal Communities	Ensuring French Language Services	Integration Of E-Health	Regional Health Human Resources Plan
Renewed community engagement and partnerships in and about the health care system:	**X**		**X**	**X**			**X**
Effective governance structures and processes							
Community awareness and engagement are core elements/processes in local health system planning				X			
Partnerships with other participants in the local health care system including public health and primary care groups	X		X				
Active participation in local community planning processes							X
Improve the health status of Ontarians:	**X**		**X**	**X**	**X**		**X**
Improved health of all Ontarians, especially groups with the poorest health status	X		X	X	X		X
Enhanced uptake of provincial disease screening programs	X						
Ontarians will have equitable access to care and services they need no matter where they live or their socio/cultural/economic status	**X**	**X**	**X**	**X**	**X**		**X**
Reduced wait times for key services	X	X	X				X
Reduced barriers to access	X	X	X	X	X		
More effective health human resource planning and management							X
Appropriate supports to enable Ontarians to age in the most appropriate place	X	X	X				
Improve the quality of health outcomes	**X**		**X**			**X**	
The consumer is at the centre of the planning and co-ordination of health services and chronic disease management	X		X				
Leadership and participation in continuous quality improvement of the health system							
Improved integration and coordination of health services and facilities related to prevention, promotion, diagnosis, treatment, rehabilitation, and palliative care that is based on the population's need	X		X			X	
Improved safety and effectiveness of health services							
Establish a framework for sustainability of the health care system that achieves the best results for consumers and the community	**X**	**X**	**X**			**X**	**X**
Equitable allocation of health resources according to the health needs of the population including disease management.	X	X					X
Optimized use of available resources to deliver health care							
Planning and decision making is based on evidence, analysis of need and value of investment							
Efficient service delivery	X		X			X	
Increased use of appropriate care settings	X	X					
The local health system is moving toward an electronic health information system						X	
Financial stability							

6.0 Current Activities

There are several current initiatives by providers in the South East LHIN that are supportive of the strategic directions of the Ministry of Health and Long-Term Care. The following are presented as examples of these initiatives. In implementing our Action Plans, we will build upon the current work of our partner organizations and capitalize on their successes to expedite realization of our objectives for more responsive, more effective and more efficient health care services in South Eastern Ontario.

6.1 Southeastern Ontario Integration Project (SOIP)

The hospitals of Southeastern Ontario have collaborated to further investigate opportunities through integration of processes and realization of efficiencies while improving service in areas such as supply chain management, human resources, information services, laboratory services and pharmacy services.

Initial Focus on Supply Chain Management

The first phase of the SOIP has begun and initially focuses on the area of supply chain management. Concurrently, funding applications to Ontario Buys for implementation analyses have also begun for the areas of human resources, information services, laboratory services and pharmacy services. The hospitals of Southeastern Ontario want to find answers as to whether cost savings may be achieved, if patient care may be improved and if there are other benefits for the hospitals and/or other interested health care organizations. The hospitals believe that it makes sense to use the strength of the organizations working together for the benefit of the patients. With limited dollars for the provision of health care, they want to ensure the resources are allocated in the best way possible.

Project Initiated Under Auspices of HCNSEO

This project was initiated under the auspices of the Health Care Network of Southeastern Ontario, a partnership of hospitals, CCACs, and some other health care providers in the region. The purpose of HCN is to provide a venue whereby services may be planned in a coordinated fashion. The South East Local Health Integration Network was asked to chair the SOIP Executive Steering Team and the Senior Director, Performance, Contracts and Allocations has served in this capacity since April, 2006. We will continue to work with the members of the HCN, as well as other health service providers in the region, to explore opportunities for integration that will result in efficiencies, improved quality of service and that will ultimately provide benefits to patients.

6.2 Wait Times Strategy

Wait Time Data Available for Five Target Service Areas.

On November 17, 2004, the Minister of Health and Long-Term Care officially announced Ontario's Wait Time Strategy. This strategy is designed to reduce wait times by improving access to health care services for adult Ontarians in five areas by December 2006: cancer surgery, selected cardiac procedures, cataract surgery, hip and knee total joint replacements, and magnetic resonance imaging (MRI) and CT scans. Wait Time information for these five services areas have been available on the web since October 2005 for all hospitals who received funding for additional wait time cases. For this purpose wait time is defined as the measure of the length of time patients had to wait from the decision to have the procedure to actually receiving the procedure. This information is posted bi-monthly on the web.

Funding for Additional Volumes in South East Hospitals

Hospitals in the South East have received funding to perform an additional 2,030 cataract surgeries, 500 hip and knee replacements, 1,130 cardiac procedures, and 280 cancer surgeries. As a result of these increases, as well as other initiatives developed by the hospitals and CCACs, the South East LHIN has experienced significant decreases in wait times for cancer surgery and cataract surgery with a 23% decrease for cancer surgery and a 40% decrease for cataract surgery (SE LHIN Wait Time Trend Analysis – April/May 2006 Data). The South East LHIN now has the third shortest wait time in the province for cataract and cancer surgery. Wait times for hip and knee replacements continue to be an area for attention in the South East. Initiatives to reduce these wait times will be a key focus for 2006/07 as access to specialized medical care is an IHSP priority as well. A concern expressed during discussions between the hospitals, the LHIN, and the Wait Time Strategy office was the potential and real impact of the Wait Time Strategy on other procedures.

Wait Time Information System.

In addition, progress continues on the development of a Wait Time Information System (WTIS) and Electronic Master Patient Index (EMPI) for the province. The EMPI or Client Registry will significantly advance the integration of services by enabling the flow of patient information across organizational silos (an IHSP focus for priority). WTIS will provide near real-time access to information and alerts when wait time priority targets are being compared at the physician, hospital, LHIN and provincial levels. This information will also be used to monitor progress made in reducing wait times at these levels and identify where improvements must be made. An ongoing issue in the South East is the desire for a regional access management tool that has more breadth than

the 5 priority service areas and more depth than simply reporting of wait times. The LHIN has led two regional discussions on this topic as well as engaged the Wait Time Strategy office in determining the applicability and possibility of utilizing a more robust tool (that would feed the WTIS) across the region. Demonstrations are planned for the hospitals not currently utilizing the tool and further senior administration and surgeon discussions will continue.

SE LHIN Focused Discussions.

In addition, during August and September 2006, the LHIN engaged in a series of focused discussions with key clinical leaders to design an effective, strategic approach for the engagement of surgeons and physicians in the further advancement of the Wait Time Strategy. It is anticipated that a major symposium will be held in the late Fall to discuss specific projects for implementation.

6.3 Surgical Efficiency Targets Program

The Surgical Efficiency Targets Program (SETP) is an adjunct to the Wait Times Strategy. Arising out of recommendations of the Surgical Process Analyses and Improvement Expert Panel of June 2005, the primary objectives are to:

Primary Objectives of Program

1. Develop consistent peri-operative measures across the province to evaluate the quality and efficiency of hospital operating rooms; and

2. Identify areas for improvement in order to optimize surgical capacity and improve the quality of care received by patients.

Focus on Performance Indicators

The initial focus of the SETP is the collection and reporting to a provincial web-based program a series of key performance indicators. Specifically, start-time accuracy, case deviation accuracy, utilization and add-on rate. The purpose of this information is to provide a detailed data analysis for daily operating room decision makers to identify and understand where performance issues that impact access and capacity may exist. This program will evolve as hospitals and LHINs work with surgical consultants to understand the results and identify specific areas and options for improvement. Later in 2006/07 a second set of indicators will be added with more productivity and quality measures. In subsequent years, LHINs and hospitals will work to set surgical efficiency targets and action plans that will improve access and capacity within the LHIN, specifically based on population need.

6.4 Critical Care Strategy

$90 Million, 4 Year Strategy.

The Critical Care Strategy in Ontario was developed as a response to the findings documented in the 2005 Final Report of the Ontario Critical Care Expert Advisory Panel. This $90 million, 4 year strategy to improve access, quality, and system integration of critical care resources in the Province involves a highly integrated 7 part program. The goal is to establish an evidence-based culture of accountability, empowerment and coordination at the hospital, LHIN and Provincial levels to:

Goals.

- Flatten the demand curve to mitigate the need for capacity investments;
- Establish a province-wide system for critical core performance measurement and quality improvement;
- Improve on the degree of standardization of best practices and critical care training; and
- Increase efficient and effective delivery of critical care service via operational management processes, and surge capacity response planning at a LHIN level.

The seven key areas for focus are:

7 Key Areas for Focus.

1. Critical care information system
2. Critical care response teams
3. System level training
4. Performance improvement collaborative
5. Ethical issues of access
6. Health human resource investments
7. Critical care capacity investments

Initial Activities and Findings.

Dr. John Muscedere has been appointed the Critical Care Lead for the SE LHIN. His initial focus has been on the development and validation of a current inventory of critical care resources in the South East. A report was submitted to the Critical Care Secretariat August 31, 2006 which, together with the provincial information, will form a baseline as to the critical care services offered in Ontario. Initial findings indicate that while the total number of critical care beds in the South East is comparable with the province, the number of mechanically ventilated beds is actually well below the provincial average as only 28% of the beds have this capability versus 61% in the province. In addition, while 101 beds are designated as critical care, 10 of these beds only have

the capability of patient monitoring, primarily for cardiac purposes. A major strength in the SE LHIN in meeting the needs of critically ill patients is the level of inter-hospital cooperation. We intend to build on this excellent base as we move forward with the implementation of the 7 key initiatives noted within the Critical Care Strategy.

7.0 Action Plan

Working with our partners, we will establish specific targets and timelines for improvement for each change initiative.

Over the next 3 years, the South East LHIN commits to the following initiatives that will focus on developing plans and implementing changes to address each of its priorities and resolve issues related to these priorities. Working with our partners, we will establish specific targets and timelines for improvement appropriate to each change initiative. We will report on our progress in achieving our objectives for each initiative.

7.1 Access to Care

The South East LHIN will further investigate, develop plans and work with others to implement system changes that will improve access to care across the LHIN. Importantly, we will work to reduce the often significant barriers to care experienced by special needs populations in the South East.

7.1.1 Access to Primary Health Care

The SE LHIN will develop and implement regional and sub-regional strategies to:

- increase the local supply of primary health care providers, and
- increase the capacity of providers to provide care.

We will focus on further developing integrated, multi-disciplinary models of primary health care.

These strategies will focus on further developing integrated, multi-disciplinary models of primary health care in the SE LHIN that have been shown to be effective vehicles for delivering primary health care services, especially for people with chronic diseases. Focusing on the use of multi-disciplinary teams, with each discipline working to the full scope of their practice, should expand the capacity of primary health care within the region by allowing other professionals, in addition to physicians, to be involved, within their scope of practice, in responding to the needs of patients.

The objectives of this initiative will be to:

1. Increase the percentage of the population with regular access to a primary health care provider or team of primary health care providers, and
2. Reduce the reliance on urban emergency departments for primary health care.

Reducing the workload of individual primary care physicians by expanding the use of other professional disciplines in

responding to patient needs should allow the primary care physician to devote more time to addressing and more often resolving the more complex medical issues of the primary team's patients[69]. This should reduce the number of unnecessary referrals to specialists and thus should reduce the queues and waiting times to access specialist physicians. Also, by increasing the capacity to provide primary health care, specialists will be able to transfer patients back to their primary health care team and thus reduce the specialists' involvement in follow-on primary health care, again increasing the capacity of specialists and their ability to accept appropriate referrals.

7.1.2 Access to Specialists

The LHIN will work with providers to recruit necessary additional medical specialists and subspecialists.

The SE LHIN will develop and implement regional strategies to:

- selectively increase the supply of medical specialists, and
- improve access to medical specialists (and supporting diagnostic services) for consultation

The objectives of this initiative will be to:

1. Reduce the number of unnecessary referrals to specialist physicians.
2. Increase the number of specialist physicians in selected subspecialties.
3. Reduce the wait time for initial access to a specialist physician.

As has been discussed increasing the supply and capacity of primary health care providers[70] will reduce the use of specialist time in providing primary health care type assessments and follow on care and thus provide more specialist time for addressing the needs of appropriate referrals. By reducing the referral rate from primary health care providers, the wait times to access a specialist for assessments and treatment planning should be reduced.

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[69] It should be noted that the increased contact with patients by primary health care providers may also uncover more health problems that require referral to specialists. This may partially offset the reduction in 'unnecessary' referrals described here.

[70] Increasing numbers of primary care physicians without changing the model of primary health care may actually increase, rather than decrease the number of referrals to specialists as more primary care physicians continue to make 'unnecessary' referrals to specialists.

Selectively, and based on its Health Human Resources Plan, the LHIN will work with providers to recruit necessary additional medical specialists and subspecialists. This too will reduce the wait time to access a specialist for assessment and treatment planning.

7.1.3 Reduce Wait Times for Treatments

We will focus on improving the queuing mechanisms for accessing services so that patients with the highest needs have priority access.

Wait time for treatment is a function of availability of human resources, technologies and facilities and the queuing models used for accessing these resources. Over the next three years the LHIN will investigate the types of services that have lengthy wait times for necessary services. For these services, in concert with the provincial wait times strategy, the LHIN will work with providers to develop plans to achieve the following objectives:

1. Reduce wait times for service,
2. Improve throughput for services,
3. Increase capacity to provide services.

The focus of these initiatives will be:

- improving the queuing mechanisms for accessing services,
- better management of the queues for service to ensure patients with highest need have priority access,
- improving the efficiency of service delivery and,
- as necessary, increasing the capacity to provide services.

7.1.4 Access to Mental Health Services and Addictions Services

We will develop and implement models of care to ensure access to appropriate and timely mental health care for residents of the more remote parts of the SE LHIN.

The SE LHIN will further investigate, develop plans and work with providers to reduce barriers to accessing existing mental health services and to increase the supply of services across the region. The SE LHIN will devote efforts toward expanding the capacity to provide mental health services and addictions services.

The objectives of these initiatives will be to:

1. Reduce the wait time for services
2. Increase the number of services that are provided within the LHIN
3. Equitably, increase the distribution of services among local communities throughout the SE LHIN

4. Increase the volume of mental health and addiction services provided within the SE LHIN

An important component of this initiative (in conjunction with the initiative to increase the capacity to provide primary health care) will be the investigation of a 'shared-care' model for mental health services that relies heavily on primary health care providers to be integral components of the system for maintaining and restoring mental health. Particular attention will be paid to developing and implementing models to ensure access to appropriate and timely mental health care for residents of the more remote parts of the SE LHIN.

7.1.5 Access to Rehabilitation Care

The SE LHIN will investigate the dimensions of the apparent deficit in rehabilitation services and develop strategies to increase capacity.

There appears to be a shortage of hospital inpatient rehabilitation services in the SE LHIN compared to other communities in Ontario. This is already a disadvantage for residents of the SE LHIN and is creating system flow issues as patients wait in acute care hospitals for access to rehabilitation services and as a result residents of the SE LHIN have difficulty in accessing inpatient acute care beds for both an emergency and elective care. The SE LHIN will investigate the dimensions of this apparent service deficit and the types of services in need of increased capacity. Addressing this issue should reduce the number of acute care beds devoted to ALC patients waiting for access to inpatient rehabilitation.

Similarly, the community is concerned about access to and the affordability of outpatient and in-home rehabilitation services. The SE LHIN will investigate the dimensions of this issue and develop plans, within the funding framework of the Ministry of Health and Long-Term Care to address the concerns and needs of the population of the SE LHIN area for these services. Improving access to in-home and outpatient rehabilitation services should improve the functional status of the population and modestly reduce the demand for long-term care services.

7.1.6 Transportation To and From Care

The SE LHIN will develop plans to improve access to transportation for care

The SE LHIN will investigate the issues surrounding transportation to and from elective care and develop plans to:

- improve access to transportation for care
- improve coordination of transportation to care
- increase the supply of transportation to care
- improve access to transportation of patients between health care facilities

- reduce the cost of transportation to care

The LHIN will also investigate and develop strategies to address the problem of securing appropriate transportation home after an episode of emergency care when personal means of transportation are unavailable or inappropriate.

7.2 Availability of Long Term Care Services

The SE LHIN will develop a plan to realign current LTC capacity to better meet the needs of the population.

The SE LHIN will work with providers to investigate the appropriateness of the current use and availability of different modalities of long-term care and to develop strategies for improvement. The SE LHIN will also work with the MOHLTC to determine the current and future need for each modality of long-term care:

- Home Support
- Home Care
- Supportive Housing
- Long Term Care Homes
- Complex Continuing Care

As necessary, the SE LHIN will develop a plan to realign current capacity to better meet the needs of the population and/or to increase the capacity of one or more long-term care modalities. The objectives of these initiatives will be to:

1. Reduce the number of people requiring institutional long-term care,
2. Reduce the length of time people wait in acute care hospitals for access to long-term care and
3. Reduce the length of time people wait in the community for access to long-term care.

7.3 Integration of Services Along the Continuum of Care

The SE LHIN will work with providers to identify and adopt best practice models for improving the flow of patients along the continuum of care.

The SE LHIN will work with health service agencies to identify and adopt best practice models in Ontario and beyond for eliminating barriers and improving the flow of patients along the continuum of care. The focus of these initiatives will be facilitating the movement of patients between providers in different geographies within a sector (e.g. acute care hospitals) and between providers in different sectors within or across geographies. Integration of services will be especially important for patients with chronic diseases who have ongoing rather than episodic interaction with multiple rather than individual elements of the health system.

7.4 Integration of E-Health

The SE LHIN will work with providers in the LHIN to first develop and then implement an integrated strategy for acquiring and deploying e-health technologies by the providers within the SE LHIN. The SE LHIN will then assist and monitor providers' performance in the implementation of the e-health strategy. The objective of this initiative will be to improve the sharing and exchange of patient information[71] among providers along the continuum of care for individual patients with the goal of providing better, safer and more efficient care.

7.5 Regional Health Human Resources Plan

The SE LHIN will develop a model for the most effective and efficient deployment of health human resources in the different sub-areas of the LHIN.

The SE LHIN will initiate activities to develop a model for the most effective and efficient deployment of health human resources in the different sub-areas of the LHIN. It will develop an inventory of existing health human resources and strategies for recruiting additional needed resources and for deploying the resulting complement of health human resources in relation to the best possible delivery of health care services.

A critical early focus of the health human resources plan will be developing a strategy that will improve the population's access to primary health care services.

Also, Health Human Resource Planning will need to focus on improving the availability of French language services within the South East LHIN.

7.6 Engagement with Aboriginal Communities

We will engage with the Aboriginal communities within the SE LHIN to ascertain issues and identify opportunities to improve health services and the health of the Aboriginal population in the SE LHIN.

7.7 Ensuring French Language Services

We will work to increase the range of health services that are available in French

We will work with the francophone community to develop a plan to improve access to French language health services in the South East LHIN. We will encourage and support

[71] It is important to note that patient privacy safeguards should be integral to the design and implementation of e-health initiatives involving sharing and exchange of patient information among providers. The Ontario Information and Privacy Commissioner has developed "Privacy Impact Assessment Guidelines for the Ontario Health Information Protection Act" that can assist in mitigating privacy risks in the introduction of new processes, systems and technologies.

initiatives designed to attract and retain French speaking service providers and facilitate access to French language health services. The focus of these initiatives will be to reduce language barriers to accessing health services for the francophone population in the South East LHIN.

Appendices

A. Findings from the Community Engagement and Stakeholder Consultation Processes

B. Findings from the Quantitative Analysis of Population Health and Health Services Utilization